Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Pex FH G934 12/21/2012 Jh State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician/ Alderson Burkes Lee 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Mays Baltimore Chapel Assisted Timonium Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex ast birthday) 8. Date of Birth **Funeral** Days 1 🙀 M 2 🗆 Months Hours Min. (Month, Day, Year) Country) Yrs **Director** 87 93-22-4823 WW 08 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location aţ Director must be notified X Yes 2 ☐ No Baltimore MD NA P 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21215 4652 Pall Mall U.S.A. Road death ! 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces' Black White etc. , o δ 1 Never Married 2 Married Yes 2 If Yes, Give Year or Dates Yes 2 □ No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify. Black "natural", Completed 3 ₩ Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Adm 2th grade Custodial Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hardy Burkes Irene King 19a. Informant's Name/Relationship (Type, Print) 19b. Mpilps CHYP1 Strein McCer or Richtern Swirl (1ce; MD), Lele 2228 ode) 4652 Pall Mall Road, Baltimore, Md 21215 Avery Burkes-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Y☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) cemetery, crematory or other place) Woodlawn Cemetery 12/28/12 Woodlawn, Md 21. Signature of neral Service 22. Name and Address of Facility
March F/H West 4 300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications shock or heart failure. List only one cause Immediate Cause (Final that caused the death, Do not enter the mode of dying, such as cardiac or reapiratory arrest, on each line. Approximate Interval Between Onset and Death neumoconios Physician/ om disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transit executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be as the b IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for (in the past 12 months? Month Day Year Yes 2 No the detached 9 Unknown P.O. signed by Part | Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Chemic certificate SM 1 Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year), 30. Name and address of person wh pleted cause of death (Item Date filed (M State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ December Day 8 2012 07:10 AM Conrad Biddinger Sr. R. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Pasadena 101 Dales Way Drive 5. Social Security Number Birthplace (State or Foreign Country)
 DC If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days May 10 1931 215-28-0052 Director 81 1 □MM 2 □ F th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be nutflied at 10b Count 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours efter death with the Maryland Director Severna Park Anne Arundel Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21146 191 Inverness Road 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ۾ 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Construction 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Pearlman Biddinger Jean John Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 191 Inverness Road, Severna Pk., MD 21146 (spouse) Antonietta Biddinger Health tem 27 Item Date 21 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If It
any injury or o Dec. 1 X Burial 2 Cremation 3 Removal from State Glen Haven Cemetery Glen Burnie, MD 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or compl Approximate Interval Between Onset and Death shock, or heart far re. List only Immediate Cause (Final Physiciani Medical resulting in death) Due to (or as a consequence of) **Æ**xaminer Carci 000 ta Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Examine Que to for as a consequence offi rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 4 Pregnant at time of death 5 Other (specify) Year 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed cononary antery disease 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No |2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of centile 29c. License number 29d. Date signed (Month, Day, Year) 3303

State Registrar 30. Name and address of pe

31. Date filed (Month, Day, Year)

802812

rson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 41503 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 L. Burnett December 1:12 A M John Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months (Month, Day, Year) December 502-28-0556 Director 1 XM 2 □ F Yrs Usual Residence of Decedent 78 Dec 1 1934 North Dakota should be filed within 72 hours and and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show it marked other than "natural", are items 25a or 28a-f show are cevent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗆 Yes 2 🄀 No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18429 Kings Hill Road United States 20874 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, ed Force Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1958–60 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Chemist 5+ Department of Energy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Clifford Orris Burnett Hazel Elsie Lambe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other tr. once. 18429 Kings Hill Rd. Elizabeth Wife Germantown, MD 20874 R. Burnett 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 12/21/2012 Woodbine, Maryland 21. Signature of Funeral Service Lic 4 ee ^{22. Name and Address of Facility}
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 el MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MINUTES myocardial infarction Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the aid be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Hunknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Cther (Specify) 1 🗌 Yes 2 12 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 17,2012 rerul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eath (Item 23a) (Type, Print)
9901 Medical Center Dmn/ Rockillt, Mostad 20850 Deborn Sherrilli MP 31. Date filed (Month, Day, Year) √32. Registrar's Signature State arked Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16:15 AM 2012 Susan Gray Beard December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Meritus Healthcare If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. Director 219-54-0007 1 M 2 XF Mar 5, 1946 Maryland Usual Residence of Decedent 66 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Hagerstown Washington MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 United States 17735 Red Oak Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Utility permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other treumatic event. <u>\$</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ambrose Snyder Frances Meyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17735 Red Oak Dr. Hagerstown, MD 21740 Robert J. Beard, Jr. / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/22/2012 Woodbine, Maryland 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician CAN CAR WITH METASTASIA BREAST Medical resulting in death) Due to (or as a consequence of): *Examiner Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death head. Physician/Medical Examiner Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No |요 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Hospital 24 hours a Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Defical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number
D 66892 29b. Signature and title of certifie A212 MOHAMMED Hagerstown, Maryland 21742 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11116 Medical Campus Rd HZIZ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

ORIGINAL

12-09539 Avon Ball, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 2 4 5 5

		1- For State Registrar	Cert	ificate of	Death		Re	g. No.	
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last) AVON BALL, JR					Date of Death Month December	Day Year	3. Time of Death 0748 hrs
eulcai Exam	1101	4a. Facility Name (if not institution, give street	et and number)	41	. City, Town, or Lo	ocation of Death		4c. County of Deat	
		University Hospital			Baltimore				
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	-1986 Co	
		Usual Residence of Decedent	2UF 20	Yrs.			02 27	1700 0.	yanay, 11D
' any		10a. State 10b. County		Town or Locatio	n				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ē	MD	BAL	TIMORE			7.00	0''' 6\\4\f\ - 1 \ 0	1 X Yes 2 No
e Mary or 28a	Director	10e. Street and Number 2210 WALBROOK AV	TATILE		10f. Zip Code		10	g. Citizen of What Cou	intry ?
death with the Maryland or items 23s or 28s-f sho must be notified at once	7	11. Marital Status 12.	Was Decedent Ever in U.S		21216 Decedent of Hisps				rican Indian, Black,
death or iten	Fune	1 Never Married 2 1	Armed Forces? Yes 2 X No	If Yes	s, specify Cuban, N	Mexican, Puerto	Rican, etc.)	White, etc.	
rs after oral", miner	Ď	3 Widowed 4 Divorced If Yes or Day 15. Decedent's Education (Specify only high	tes:		res 2 No SUsual Occupation	specify: n (Give kind of)	work done	Specify: BLAC	
72 hou	Completed		ollege (1-4 or 5+)		st of working life. D				
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21215-0036 21215-0036 Puld be filed within 7 Mental Hygiene. marked other than ic event, the Medis;	Be Co	17. Father's Name (First, Middle, Last) AVON BALL, SR			18		(First, Middle, M LINE HAI		
10re, MD 21215-0036 gges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. 1: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once	TO E	19a. Informant's Name/Relationship (Type, F						per, City or Town, State	e, Zip Code)
re, MD ; ss I and 2 sho of Health and If item 27 is her traumati		JEANETTE HENDERSON/			DENISON on (Name of ceme		LTO., MI	21229 20c. Location - City o	Town State
Baltimore, Mormit. Pages 1 and 2 Department of Health Important: If item 2 njury or other traun		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	moval from State	ematory or othe		- 1	22/12	BALTIMORE,	
.트 스 핑 등 능		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		15-73	me and Address o				ONS F.H., INC
Balti permit. Departi Importi		James a.	Morton	17	01 LAURE	NS ST.,	BALTO.	MD 21217	MB 1:11:,110
Physician Medi	3	23a Part 1. Enter the disease, or complication failure. List only one cause on each lin	Э,		mode of dying, su	uch as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
xaminer			ple Gunshot Wound		-				Death
- "		Sequentially list conditions, b							
	jue	cause. Enter Underlying Cause	(or as a consequence of):	:					
od Sit	Examiner	(Disease or injury that initiated events resulting in death) Last	(or as a consequence of)	:					
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ox 687 eath certific attending		23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of dea	=	I death 3 er (Specify)	Ectopic pregna	ancy	Month	Day Year
Box 68' re death certifi the attending	Physiclan/	1 Yes 2 No 9 Unknown 9	Unknown	J Othe	er (Specify)				
P.O.	DA P	Part II. Other significant conditions conti	buting to death but not res	sulting in the un	derlying cause give	en in Part I.		2 ✓ No 3 Pro	
ords, P.C w requires that is been signed should be deta							24a. Was a		utopsy findings available
COFC	Completed		-				autops	ned? death?	completion of cause of
Vital Rec ysician: The l his certificate l		25. Was case referred to medical			26.Place o	f Death (Check	1 ✓ Yes 2 only one)	No 1 ✓ Y	es 2 No
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should I	To Be	examiner? 1 ✓ Yes 2 No	·	ER/Outpatient	3 DOA	ther Nursin	ng Home 5 F		or:
ding Ph After th		27. Manner of Death 1 Natural 5 Pending	(Month Day Year)	28b. Time of Inj 0245 hrs		at Work? s 2 ✔ No	28d, Describe h Subject shot	ow injury occurred	
Atten Atten r death ection: by the	cati	2 Accident Investigation	8e. Place of Injury - At hor	ne, farm, street,			28f. Location (S	treet and Number or R	ural Route Number, City
Division pital or Atten ours after death neral Director: filled in by the	Certification:	Suicide Could not be	Specify) Local Street				or Town, St 1000 Block of	^{ate)} Madison Ave, Baltin	nore, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		20- 0-46	the best of my knowledge	e, death occurre	ed at the time, date	and place, and	due to the cause	e(s) and manner as sta	ted.
To th within To th compl	Medical	29b. Signature and title of certifier	ne basis of examination and namer stated.	GOI IIIVestigatio	29c. License		at the time, date a	29d. Date signed (Mo	
		0 7			O.C.M			December 16, 2	
	}	30. Name and address of person who compl	eted cause of death (Item 2						
			stant Medical Exam		V. Baltimore S	Street, Baltir	nore, MD 212	223	
S ⁱ Regis		31. Date filed (Month, Day, Year) NFC 2 1 2012	32. Registrar's Signature	Jane	d				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41506 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Behringer December 16, 2012 7:50 a M August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Elizabeth's Nursing Home Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 218-26-9878 Director 1 **K** M 2 □ F July 18, 1930 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD 1 X Yes 2 No Baltimore 0 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 3641 Hineline Road 21229 USA within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 10 ' 1 X Never Married 2 Married þ 1 XYes 2 If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates. Korea the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic seconds. Elementary/Secondary (0-12) College (1-4 or 5+) Meat Inspector U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kar1 Behringer Theresa G. Vollmert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred Behringer 3641 Hineline Rd., Baltimore, (Brother) MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 12/20/12 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD. 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ardiovasula Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the use as f IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 2 No 9 Unknown Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No protern 1 Yes 2 No the funeral director, 25. Was ca e eferred to medical Be 26. Place of Death (Check only one) examiner? 2 **19**-No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: After t 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation

Division of Vital Records, P.O. Box 68760

or Attending Physician: after death within 24 hours a

To the Funeral C To the Funer completely fi

State Registrar

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

Suicide

29a. Certifier

only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

filled in by

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D24781

NTS

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Decorber

29d. Date signed (Month, Day, Year)

MOY

2012

MAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ DECEMBER Day 8 2012 06:18Рм BROWNSTEIN **GERTRUDE** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Hours Director 215-56-6949 1 DM 2 X F 100 Yrs. 01/01/1912 MD irel", or items 23e or 28a-f show Exeminer must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4730 ATRIUM COURT, #524 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "naturel", 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER 12 OWN HOME Be permit. Page 1 and 2 should be filed. Department of Health end Mental Himportant: If item 27 is more eny injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HYMAN FISHBONE IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SLADE AVENUE, #901, PIKESVILLE, MD 21208 ANNETTE COOPER / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORBAND CEMETERY 12/20/2012 ROSEDALE, MD 21. Signalure of Funeral Service Lige 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the node of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Fudou Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funerel director, page 2 should be deteched for use as the buriel-trensit ending physicien and use es the buriel-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medicai 🔌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certify Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ 6 only one) and title q 29c. License number 29d. Date signed (Month, Day, Year) 0071782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10f 6

State

Registrar

31. Date filed (Month, Day, Year)

2012

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 45 PM 12 Physician/ Month ne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Inpatient Care Center Harwood 5. Social Security Number 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Days (Month, Day, Year) Country) 515-28-7079 Director 1 M 2 XXF 09-13-1927 Iran 85 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Millersville MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 753 Stacy Oak Court 21108 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married 5 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify: 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Medical Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Judith Dooman Vahe der Hacopian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 753 Stacy Oak Court, Millersville, MD 21108 Judy A. Bowen - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 12-18-2012 Glen Burnie, MD Atlantic Crematory 4 ☐ Denation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Signature of Funeral San MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode claying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examine Due to for as a consequence ont il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available 24a Was an autopsy performed Yes 2 prior to completion of cause of this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physicien: in 24 hours after death.
the Funeral Director: After this certificampletely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2/ No Certificate; To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie To the Hosp within 24 hou To the Funel completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.

3 Certifying Norse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Signature and title of certifier 29d. Date signed (Month, Day, Year) ecomba

Registrar

State

Annapolis

se of death (Item 23a) (Type, Print)

2. Registrar's Signature

address of person who completed car

31. Date filed (Month, Day, Year)

2

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Item 5 per fh 9939 5-8-13 vt State of Maryland / Department of Health and Mental Hygiene? Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month bel Medical ne (f not institution, give street and num Examiner n, or Location of Death 4c. County of Death e (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Director 1 X M 2 □ F 45 June 27, 1967 Kentucky 28a-f show should be filed within 72 hours after death with the Maryland and Mentel Hygiene.

Is marked other then "natural", or items 23a or 28a-f shov 10a. State 10b, County item 27 is marked other then "natural", or items 23a or 28a-f sho other traumatic event, the Modical Experiment ust be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12107 Dewey Road 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) M Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Computer Engineer Computer Networking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marcia Ann Fitzsimmons Peter Brandel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is eny injury or other trai 523 Cline Ave., Mansfield, OH 44907 Peter Brandel (Father) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Mansfield
Memorial Park 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 12-19-2012 Mansfield, Ohio 21. Sig. ature of Fureral Service Licen 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Amaic Regurgitation Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 5 Other (specify) Day this certificate has been signed by the a rial director, page 2 should be detached it 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Deatl Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14rh doid 30. Name and address of person who complet i 23a) (Type, Print) Matthew 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 : 5 5 P Physician/ December 2018 2042 Gerhard Ernst Bauch Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 10/08/1923 Days Hours Country) Germany Director 1 ÅM 2 □ F 214-60-1719 89 I Hygiene. other then "naturel", or items 23e or 28e-f show vent, the Medical Evanders must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Frederick Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3614 Singleton Terrace 21754 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: 3 DWidowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Business Owner** Export Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 end 2 should be file of Heelth end Mental F item 27 is marked o ဂ္ Unkn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 Department of Heelth Importent: If item 27 eny Injury or other tr Angelika Iapicca / Daughter 5700 Carnoustie Pl, Ijamsville, MD 21754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 12/21/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medicai Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physicien and for use es the burlel-transit Hospital or Attending Physicien: The lew requires that the deeth certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 24 hours efter de Funerei Directo letely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hound to the second 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cecitying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Linda Borman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** Union Memorial Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year, 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. Country) 216-44-0571 Director 67 1 🗆 M 2 🔀 F MD Aug 9, 1945 Yrs Usual Residence of Deceden 10b. Count 10a. State 10c. City, Town or Location 10d. Inside Sity Limits Director MD **Baltimore City Baltimore** Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3514 Roland Ave 21211 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 1 ☐ Yes 2 No White If Yes Give Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **Barnes** Harry Alice Espey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3561 Rodgers Ave Ellicott City, MD 21043 Janet Bloom cousin 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Dec 17, 2012 Glen Burnie, MD Atlantic Crematory, LLC 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 unature of Funeral Se Part 1. Enter the distaste, or complications that each shock, or heart failure. List only one cause on each used the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due Examiner fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the Hospital or Attending Physician: The law equires that the death certificate be executed the attending physician and the for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent prequant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) detached g Unknown 9 Unknown teen signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DO/ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 🗌 Yes death. 2 🗌 No eral Director: / filled in by the the f ☐ Accident ☐ Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19,2012 Mary Lynn Benner December 11:15 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Perry Hall Baltimore 4121 Baker Lane Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 218-98-4142 Days Hours Min. (Month, Day, Year) **Director** 48 1 M 2 XF November4,1964 Maryland Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗆 Yes 2 🖺 No Maryland Baltimore Perry Hall 10e. Street and Number 4121 Baker Lane 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 21236 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 ☐ No Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event *****. (Give kind of work done during most of working N/A life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Benner Dorothy Eisenhauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2612 Gunpowder Farms Road, Fallston, Maryland 21047 Mrs. Verna Carson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CremationCenterofMaryland 12-21-12 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses michael 6009Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or com wations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law required the standard within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director, page 2. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence <u>မ</u>ူ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Leonard Wallace Buhner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO APPIONAL MEDICAL Centu SALISBUIL FENINSHUM Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min. (Month, Day, Year) 129-14-0936 Director 1 🕅 M 2 🗆 F 11/06/1924 88 New York an "natural", or items 23a or 28a-f show Medical Exeminer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21804 608 Eastgate Village 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) treumatic event, the Pipefitter Construction Unknown 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F is marked o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tre. once. 301 Gilliss Court, Salisbury, MD 21804 Norris Gillis / Step Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 12/20/2012 | Hanover, Maryland Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) ASCVD Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year signed by the at Id be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been sig ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 124 hours after death, e Funeral Director: After this certificate it pletely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) MD 00070129 12/19/2012

Registrar

State

IRFAN

31. Date filed (Month, Day, Year)

CARROLL STREET, SALISBURY,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

2. Registrar's Signature

EAST

MOINUDDIN

DEC 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 5:19 PM 2012 SOROV Diana December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Min. 1 □ M 2 🖵 F Months Days Hours 213 92 8691 36 11/15/1976 Maryland **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, t<u>he Medical Examiner must be notified at</u> 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1916 Searles Road 21222 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: 2 Specify: White 3 Widowed 4 NDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Hair Stylist Salon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be on the stand of Health and Mental I and the surt: If item 27 is marked o Robert Paul Breeden Barbara Bailev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Almes (mother) Mechanicsville, Virginia 23111 7020 Hanna Drive permit. Pages 1 and Department of Healt Important: If item 2 any injury or other. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Inc 12/19/2012 Baltimore Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA ature of Funeral Service Licenses 1407 Old Eastern Avenue Essex Maryland 21221 Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) erebral **Physician Medical** Examiner Streptococcus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): influenza law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 2 Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 No The 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient examiner? Other: 4 \(\triangle \) Nursing Home \(\frac{5 \(\triangle \)}{2 \(\triangle \)} \) Residence 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ဂ္ filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: Division 1 Natural
2 Accident (Month, Day Year) Attending 5 Pending investigation Injury 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. To the I within 2 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Kar 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/200 11595

of Vital

12-09644 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jevonda Cagan State of Maryland / Department of Health and Mental Hygiene 2012 41515 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 18, 2012 **Medical Examiner** 2042 hrs Jevonda Cagan 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale **Baltimore County** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Hours Min Days Director 1 M 2 X F Country 093-58-3577 38 5/17/1974 New York Usual Residence of Decedent in, 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No s 23a or 28a-f show 28a-f show with the Maryland Maryland Baltimore Perry Hall Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 Wragby Court Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 1 Armed Forces? White etc. 1 Never Married 2 X Married Yes hours after 4 Divorced If Yes, Give Year 1 Yes 2 X No specify. Specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If iten 27 is marked other than ", injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Corporate Law Legal Secretary 17, Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Thomas Redonnie Duane Sherman Roxane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Louis Cagan (Husband) 8 Wragby Court Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 12/21/2012 4 Donation 5 Other Specify. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each linf Medicul Death Acute hepatic necrosis of undetermined origin Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit es that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g936 2-13-13 sm X UNPENDED attending physician or use as the burial -Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed by be detach ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, Hospital or Attending Physician: The law requir 24a. Was an 24b. Were autoosy findings available prior to completion of cause of autopsy has . death? performed? page ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 28a Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 Natural unknown 5 Pending 1 Yes 2 X No 24 hours after death. Funeral Director: in by the fd 12-18-12 fd 19:26 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be or Town, State 8 Wragby Ct. rry Hall, MD. Townhouse/Rowhouse determined Perry Hall 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the the ch

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

aus,

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner

State Registrar barke

egistrar's Signatur

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

December 19, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time or 2 9:40p M Physician/ De Center Deborah Ann Cook Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tal Hunose 7.0 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth (Month, Day, Year) 212-68-9276 Director 1 □ M 2 🔀 F 2/26/1956 56 MD r then "netural", or itams 23e or 28e-f shov the Medical Evaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Woodbine Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6945 Eden Mill Rd. 21797 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced **Black** Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hyglene, nerkad othar then Elementary/Secondary (0-12) College (1-4 or 5+) 12 Aide Group Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Martha Ann Lowman Edward Alfred Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6945 Eden Mill Rd., Woodbine, MD 21797 Martha Ann Cook/Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pega 1 Department of important: if it any injury or o 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) White Rock Cemetery 12/22/2012 Sykesville, MD 21. Signature of Funeral Service Lice 22. Name and Address Office Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate disease of Onset and Death Cause (Final Physician/ Medical in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine attending physicien and I for use as the burlei-transit The lew requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day signad by the at id ba deteched fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funaral director, pege 2 autopsy 1 ☐ Yes 2 ☐ No Yes 2 W Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attanding Natural 5 Pending injury To the Hospitel or Attanding within 24 hours after death. To the Funerel Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier p-Sinai Hospital Registrar

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Debrah

12-09516 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Clifton Curtis, Jr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** December 14, 2012 Curtis Jr. Clifton 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3600 W. Franklin Street Apt. 3J 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Day Hours Director Months Min 214-72-8157 1 X M 2 55 09 18 57 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No 28a-f show Baltimore must be notified at once. MD NΙΔ hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 21229 U.S.A. 3600 West Franklin Street #3J Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 5 imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. Divorced Give Year Yes 2X No specify: Black Specify þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Taylor Clifton Curtis Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9737 Conmar Road, Middle River, Md 21220 Vernetta Braxton-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Department or Important: I injury or other Baltimore, 12/20/12 Metro Donation 5 Other Specify: Signature of Funeral Service Licenses March Adresh Facility 21215 4300 Wabash Ave, Baltimore, 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical the attending physician ed for use as the burial UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy 2 Pregnant at time of death 5 Other (Specify) signed by the att I be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Morbid obesity pleted director, page 2 should peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has l performed? Com Yes 2 V No 1 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ this Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene ဥ 1 V Yes

0910 hrs

MD

Death

Year

2 No

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

funeral After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27, Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 V Natural Pending Yes 2 To the Funeral Director: completely filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. g 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 15, 2012 30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State barker Registra DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 18, 2012 2:30 P M Alec Kenneth Cameron Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign **Director** 219-36-8226 1 ፟ M 2 □ F 1939 73 Washington DC Oct 6, Usual Residence of Decede ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 13504 Dowlais Drive 20853 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. δ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: If Yes, Give Specify: 3 🗌 Widowed 4 🗎 Divorced Completed White Year or Dates. 1963-65 traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other tt Software 4 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Elliott Angus John Cameron Hazel and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13504 Dowlais Dr. Rockville, MD Virginia Cameron / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/21/2012 Woodbine, Maryland 21. Sign we of Funeral Service Lig Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respirator Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Bronchio litis organizing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Preumonia Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 🗌 No 1 Yes 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 Pinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who by the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of the bast of my kin, who because the country of t (Check only one 29b. Signature and title of certifier enopaell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Cor dr Rockville, MD 20450 9901 Ushakiran Yeniqalla MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 1 Registrar

DHMH 17 Rev 06-2011

1430

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 9.12.15.16a-b.19a.20a-c.per INF.g934 12-21-12 SM State of Maryland / Department of Health and Mental Hygiene 2 0 2 For State Registrar AMEND ITEM#10e,12h meret of 35ath/2/2013, WS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3:00 AM Dicember 10, Zoiz Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** topkins HOSPATA Johns a Himor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country 117). . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. (Month, Day, Year) Months Hours Director 226-08-9942 57 1 🔀 M 2 🗆 F Yrs Virginia 10. Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🎦 No Anne Arundel Severn MD 10g. Citizen of What Country? USA 10f. Zip Code 10e. Street and Number 21144 Funeral 8307 Severn Orchard Circle 12. Was Decedent Ever in U.S.

Armed Forces? unlt

1 ☐ Yes 2 ☐ No

If Yes, Give 1985-2000

Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Specify: black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation HINE
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) State Of Maryland Case Manager unk unk -Be 17. Father's Name (First, Middle, Last) 1117 k. 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) Angelita R. Crawford Angelia Crawford - V 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8307 Severn Orchard; Severn, MD 21144 wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in State West Arundel Crematory 12/18/2012 Odenton, Maryland 22. Name and Address of Facility State Anatomy Board Donaldson Funeral Home & Crematory MD-14TP Annapolits Rull Odenton MD-21113 MD-Signalure of Funer I Service Licensee Ronal S. Wade, 21201 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final reumonia Physician/ disease or condition resulting in death) Medical (or as a consequence of): Cancer Examiner Varessive Sequentially list conditions. Examine if any, leading to inniediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The lew requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) a
Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ page 2 should be 2 A 3 Probably 4 Unknown 1 🗌 Yes Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 2| 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MIS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rleans St. Baltimore, MD. 21287 ていまろ HATIUM MA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 9 2012 DEC ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Of Maryland State Registrar		tificate of Dea			Reg. No.	2012	41520
ì	Physicia		Decedent's Name (First, Middle, Last) Rosalie Janowiak		Cessna		2. Date of Dea		201 ^{Year}	3. Time of Death 9:30 A. M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc		DEC.	1	ounty of Death	J.30 III W
· /	<u></u>	М	1410 St. Marks Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last	for institution of	Baltimor	-	O Data of Dist			Land (Otata and Estation
	Funeral Director		218-26-7504 1	Yrs.		ours Min.	8. Date of Birtl	1929	Goun	place (State or Foreign try) MD
	land show d at	tor	10a. State 10b. County 10c. City, T	own or Loc	ation				1	0d. Inside City Limits
	Mary 28a-f	Director		imore						1XXYes 2 □ No
	vith the 23a or st be r		10e. Street and Number 1410 St. Marks Avenue		10f. Zip Code 21230			-	en of What Co <i>u</i> r J .S.A.	ntry?
	leath v items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	/as Decedent of Hispar Yes, specify Cuban, M	nic Origin? (Spe	cify Yes or No-		l. Race - Americ	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ X Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Yes 2 X No S		ncan, etc.)	Sp	Black, White, pecify: Wh	nite
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ryla	2 should be file h and Mental h 7 is marked o traumatic eve	o	Frank Janowiak				Potoki			
	and 2 sho Health an tem 27 is I	13	1		g Address <i>(Street and I</i> Saint Mark			-		
Baltimore,			20a. Method of Disposition 1 X X Burial 2 Cremation 3 Removal from State	e of Dispos etery, crem	sition (Name of atory or other place)	С	ate	20c. Loca	ation - City or To	own, State
<u>=</u>	permit. Page 1 Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify) Mead		ge Mem. Pk					
Ba	perm Depa Impo any i	100	21. Signature of Fundal Service Licensie		Name and Address of P, Inc.,72					
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final					est,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequen		mer's De	emen 11				
		iner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequen	ce of):						
	icate be executed physician and s the burial-transit	Examiner	Cause. Enter Unidentying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequen	ce of):						
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6876	irtificat ling ph e as th		IF FEMALE:							
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P.O.	hat the ed by t detach	by Phy	Part II. Other significant conditions contributing to death but not resulti	ng in the ur	nderlying cause given in	n Part I.	23e. Did to	bacco use	contribute to the	ne cause of death?
	quires quires en sigr	ted b	Failure to Thrive				1 🗆 ነ	Yes 2	No 3 ☐ Pro	bably 4 🗆 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. I Director. After this certificate has been signed by the din by the funeral director, page 2 should be detach.	ne law re te has be age 2 sho	Completed	Osteoporosis				rmed?	24b. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of	
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o uc	nding ath. r: After e funer	icate	1 Matural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work?	2 🗆 No	8d. Describe h	ow injury o	occurred	
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_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2.	Medical	29a. Certifier (Check (Check Check Check (Check Check	nd/or investi	gation, in my opinion, de	eath occurred at	the time, date a	nd place, a	nd due to the ca	use(s) and manner stated.
	To the within To the compl	Σ	only one) 3 ☐ Certifying Nurse Practioner: To the best of my kr 29b. Signature and title of certifier	iowieage, d	29c. License nun	mber			signed (Month,	
			▶ Rodolfo Fernandez MD		0503	503		12	19/12	
	av		30 Name and address of person who completed cause of death (Item 23 Rodolb Fernandez - 516N Ro	Ba) (Type, Pi	ent) Rd Ste 7	20T C	etrush	llem	9 212	28
	Stat Registra		Rodollo Fernande, - 516 N R 31. Date filed (Month, Day Year) OEC 2 1 2012 Security Signature	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 | 4 | 52 |

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ M∼dical Examiner 2107 hrs December 15, 2012 CONOUEST EDWARD 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Maryland General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Director 39 Country) 1 XM 2 F /16/1973 MD 218-84-9229 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. GWYNN OAK Director 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 WALDON CEDAR items 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 3 Widowed 4 Divorced Yes 2X No specify: Specify: BLACK 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) DISH DOMESTIC WASHER 17. Father's Name (First, Middle, Last) 1B.Mother's Name (First, Middle, Maiden Surname) Be DARLENE BURLEY JOHN E. CONQUEST SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 407 S. BEECHFIELD AVE. BALTIMORE, MD 21229 ANDREA M. CARROLL/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore, Juit. Pages I av Department of F Important: I' 1 X Buriai 2 Cremation 3 Removal from State crematory or other place) ZION CEMETERY 12-27-2012 BALTIMORE, MD Donation 5 Other Specify 21. Signature of Fu 22 Name and Address of Facility COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE. BALTIMORE, MD 21217 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resoliratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line een Onset and /Medical Death a Dilated Cardiomyopathy Immediate Cause (Final disease Ėxaminer or condition resulting in death) Due to (or as a consequence of) b.Mitral Valve Prolapse Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED 23a-b, 27, per me, g934 12-26-12 sm X UNPENDED attending physician or use as the burial The law requires that the death certificate be Records, P.O. Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed ficate has been si page 2 should b 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes certificate the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital æ Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: DOA After this funeral dire 1 Yes 2Bb. Time of Injury 2Bc. Injury at Work? 2Bd. Describe how injury occurred 27. Manner of Death 2Ba. Date of Injury (Month, Day, Year) Certification: 1 X Natural 1 Yes 2 No Pending Director: d in by the f death 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City hours after 3 Suicide 6 Could not be or Town, State) within 24 hours a

To the Funeral I 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of pertifie 29c. License number 29d. Date signed (Month, Day, Year) December 16, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) CUNE Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Charmaine M. DePriest 2:00 A. M December 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Hammonds Lane Anne Arundel Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9 Rirthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) 212 30 3492 Director 1 □ M 2 🗓 F 81 07/29/1931 Pennsylvania permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ahow amy injury or other traumetic event, the Madical Evaminar must be autilied at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S.A. 304 Panorama Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Divorced 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Westinghouse 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Davis Elynid Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Buchanan / Daughter 304 Panorama Way Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Toremation 3 Removal from State 12/19/2012 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that c used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Marth Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or miury Examiner Due to (or as a consequence of pate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physicien: The lew requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

leral Director: After this certificate has filled in by the funeral director, page 2 death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Other: မြ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours within 24 hours

To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Wein 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1.	For State Registrar	State of Marylan	Certifica	te of Death	Reg. N	2012 415
Physician		Decedent's Name (First, Middle, Las				2. Date of Death	ay Year 3. Time of Deat
/Medical Examiner uneral irector	5.	Social Security Number 6. S. 216. 32. 1313	Nor Nursing	Pi	Kesylle Market Year If Under 24 Hrs. Days Hours Min.	16	c. County of Death Baltimore
'natural", or Itams 23a or 28a-f show ideal Eveninat must be notified at letted by Funeral Director	10	sual Residence of Decedent Da. State 10b. County Baltic De. Street and Number	more 10c. City	/, Town or Location WDOd 10f. 2	awn ip Code	10g. 0	10d. Inside City Lir 1 □ Yes 2
inst rust be notified inst rust be notified Funeral Director	3 11	6743 Townbrod Marital Status	L Drive Apt.	F 13. Was Dec	21207 edent of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - American Indian,
Eveniner	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1	If Yes, sp 1 □ Yes	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puert 2 3 No <i>Specify:</i>	b Rican, etc.)	Black, White, etc. Specify: African American
m dm	_	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation (de completed) College (1-4or 5+)	life. DO NOT	ork done during most of wor		Kind of Business/Industry HURCH HOME HOSPITAL
d out	17	7. Father's Name (First, Middle, Last)	1	1	18. Mother's Nan	ne (First, Middle, Maide Walker	
	19	9a. Informant's Name/Relationship (3 Rodney Hill / S	Type. Print)	410 Bal	MORAL CIRCLE	Pikewille	
Department of them 2 any Injury or other 200ce.		Da. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 1. Signature of Funeral Service Licen	Removal from State	lace of Disposition (Nemetery, crematory or	other place) 19 tense 122	6/2012 Ba	ltimore, MD ene Funeral services
any l	1	3a. Part 1. Enter/the disease, or comp		8728	Liberty Road	Randall	town mo 21133 Approximate
physician and street burial-transit sthe burial-transit and response adjical Examiner	Si if Ca	mmediate Cause (Final isease or condition soutling in death) equentially list conditions, any, leading to immediate ause. E.tite U. derlying ause (Disease or injury lat initialed events soutling in death) Last	a. Due to (or as a consequence)	uence of):	ct dem	entra	Onset and Death
s been signed by the attending p should be detached for use as should by Physician/Mec	IF 23	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 M2 No	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of d 9 Unknown	11.	23d. Date of delivery Month Day Year		
deta deta	Pē	art II Other significant conditions o	ontributing to death but not resu	cause given in Part I.		23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	
en signe suld be d ed by		The other significant conditions of				1 ☐ Yes	2 No 3 Probably 4 Onkr
2 0	_					24a. Was an autopsy performed 1 □ Yes 2 ☑	24b. Were autopsy findings avail prior to completion of cause death?
his certificate has I director, page 2 To Be Comp	25	5. Was case referred to medical examiner? 1 □ Yes 2 □ No 7. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 1 28b. Time of Injury	OOA Other: 4 Nursing F 28c. Injury at Work?	24a. Was an autopsy performed	24b. Were autopsy findings avaired prior to completion of cause death? 1
his certificate has I director, page 2 To Be Comp	25	5. Was case referred to medical examiner? 1 □ Yes 2 □ No 7. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	OOA Other: 4 Nursing H 28c. Injury at Work? 1 Yes 2 No	24a. Was an autopsy performed; 1 □ Yes 2 ☑ 1th (Check only one) tome 5 □ Residence 28d. Describe how in	24b. Were autopsy findings avail prior to completion of cause death? No 1 Yes 2 No 6 Other (Specify) jury occurred
his certificate has I director, page 2 To Be Comp	25	5. Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Pending determined	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At ho building, etc. (Specify	28b. Time of Injury M ome, farm, street, factor //	OOA Other: 4 Nursing H 28c. Injury at Work? 1 Yes 2 No ry, office	24a. Was an autopsy performed; 1 □ Yes 2 ☑ th (Check only one) tome 5 □ Residence 28d. Describe how in 28f. Location (Street City or Town, Street, and due to the cause	24b. Were autopsy findings avail prior to completion of cause death? 1
this certificate has all director, page 2	27	5. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At ho building, etc. (Specify Injury) 28e. Place of Injury - At ho building, etc. (Specify Injury) 28e. Place of Injury - At ho building, etc. (Specify Injury) 28e. Place of Injury - At ho building, etc. (Specify Injury) 28e. Place of Injury - At ho building, etc. (Specify Injury)	28b. Time of Injury M me, farm, street, factor wledge, death occurre tion and/or investigation	OOA Other: 4 Nursing H 28c. Injury at Work? 1 Yes 2 No ry, office ad at the time, date and place on, in my opinion, death occurrence of the second of the	24a. Was an autopsy performed; 1 Yes 2 Inth (Check only one) 1	24b. Were autopsy findings avail prior to completion of cause death? 1

DHMH 17 Rev 1/2001

Denhardt Cynthia

State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 5.39 Physician/ 2013 Cynthia Mae Denhardt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPItal Square Franklin Baltimore ROSeda 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/07/1960 Birthplace (State or Foreign Country) Social Security Number Funeral Months Davs Hours Min. 1 □ M 2 🛈 F Director 217-80-7424 Maryland Usual Residence of Decedent or than "natural", or items 23e or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 ☐ No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9713 Birdriver Road 21220 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Eracia ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Did Not Work 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Shaver Irene McCauley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Osha Vogel / Daughter 4731 Shamrock Avenue, Baltimore, MD 21220 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/19/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility 1 Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Asteriosclerotic disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of e Hospital or Attending Physiclen: The law requires that the death certificate be executed 124 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Funer

completely fil 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 12 2012 Attending Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 m 31. Date filed (Month, Day, Year) State 2012 **DEC 2 1** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41525 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month <u>Patricia</u> Ann 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 216-38-0126 1 🗆 M 2 🚻 F 04/22/1941 Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 K Yes 2 No Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? <u>369 Woodpoint Avenue</u> 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces 1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Emerson Sickler Genevieve Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Dunkin, Sr. / Husband 369 Woodpoint Avenue, Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 12/19/2012 | Hanover, Maryland 21. Sign ture of Funer I Service 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstruchi disease or condition monory resulting in death) Due to (or as a consequence of): neumonio Due to (or as a consequence of): yourdia Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year 1 Yes 2 No q Unknown 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical Examiner

attending physician and I for use as the burial-transit

Box 68760

Division of Vital Records, P.O.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlal-transit

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene.
27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

item 27

permit. Page 1 a Department of H Important: If ite any Injury or ot

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Examir

Physician/Medical

Completed by

Be

유

Certificate:

Medical

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a, Was an autopsy performed' 1 Yes 2 No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 2 40 1 🗌 Yes 27. Manner of Death

1 Natural

Accident

3 Suicide 4 Homicide

29a. Certifier

1 Prinpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

162588

26. Place of Death (Check only one)

29d, Date signed (Month, Day, Year) 12-18-2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUNITY TA ANIA ON 11116 Mcdical Campus Road, Thegershoun, M

determined

MSAOUA 31. Date filed (Month, Day, Year)

3. Registrar's Signatu **DEC 2 1 2012**

a no

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:52 am Butler Dunn, II 701 Anne Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Baltimore City N/A 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 216-46-3946 Months Director 1 M 2 TX F Yrs 3, 80 1932 Maryland Sept. 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director mit. Page 1 and 2 should be filed within 72 hours after death with the Marylar partment of Health and Mentel Hygiene. sortant: If item 27 is marked other than "netural", or items 23a or 28e-f sinjury or other traumetic event, the Medical Examiner must be notified. 1XXXYes 2 □ No N/A Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 W. 40th Street 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Š ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes. Give Completed 3 Divorced 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) At Home Never Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Edward Κ. Dunn Butler Anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pierce B. Dunn/Brother 901 South Bond St. Suite 400 Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Druid Ridge Cemetery 12/22/12 Baltimore, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Kohae 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ eumm pivater disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed After this certificete hes been signed by the attending physicien and funeral director, pege 2 should be deteched for use es the buriel-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 Z No 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director, and the funeral director, completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 📉 No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred i or Attending F after death. (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident M Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of pertifier 8 MD D0064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I 31. Date filed (Month, Day, Year, State Registrar's Signat DEC 2 1 2012 Registrar

State of Maryland / Department of Health and Mental Hygien U State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Himore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs **Funeral** Director 1 🗆 M 2 💢 F 69 dence of Decedent in then "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 No more 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21239 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other then 'any Injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Brot. Mula 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician year disease or condition resulting in death) Medical Due to (or a consequence of): Examiner 1000 Sequentially list conditions, it any, leading to in mediate cause. Enter Underlying Examine 200 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎉 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 00 f person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vera L. Fuchs P M 2012 Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2101 Tred Avon Rd. Baltimore Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Director 219 16 5037 1 □ M 2 🔯 F 89 Feb.22,1923 Maryland or 28e-f shov 10b. County 1 and 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene. item 27 is marked other then "natural", or items 23e or 28e-f sho other treumatic event, the Madical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2101 Tred Avon Rd. 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 Yes 2 No Specify Specify: White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Phone Company Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edwin C. Reisz Margaret E. Schachert permit. Page 1 and 2 should be Department of Health end Men Importent: if item 27 is marke eny injury or other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Fuchs Sr. (Son) 2125 Tred Avon Rd. Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 12/22/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. Signature of Funeral Service Licensee ohn W. Bur 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burlal-transit Exami requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ettending physician I for use as the burla Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death detached 9 Unknown 9 Unknow Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş been signer should be c Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Hospital or Attending Physicien: The law hes autopsy death? 1 ☐ Yes 2 ☐ No After this certificate Yes **Director:** After this certific d in by the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? death. Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year, of person who completed cause of death (Item 23a) (Type, Print) 2300 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2012 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decadent's Name (First, Middle, Last) Month :45PM **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death e street and number) Examiner ton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Hours Min 1 □ M 2 🖾 F 08/03/1927 South Carolina 85 577-68-2097 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State f Health and Menial Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28a-1 ehow other traumstic event, Ite Medical Examinar must be notified at 1 X Yes 2 □ No Directo Clinton Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20735 U.S.A. 7520 Surratts Road Completed by Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Item any injury or other fraumatic event, Ita Medical Exprin 1 ☐ Yes 2 🔀 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minick Shaddie 2 Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7481 Lee Highway, Apt. 322, Falls Church, VA 22042 Jamescinee Glenn / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/19/2012 Hanover, Maryland 4 ☑Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Fluneral acryice Livernice 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760. attending physician Completed by Physiclan/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 2 2 3 No 3 Ectopic pregnancy Month Day Jo 5 Other (specify) P.O. should be detached the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. 3 ☐ Probably 4 ☐ Unknown 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 2 No 1 Yes 1 Yes the Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes _2 No 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 28b. Time of Division 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after deat • Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Momicide completely filled t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type,

State Registrar 31. Date filed (Month, Day, Year)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # Sper PHY 6934 / 12/21/2012 The alth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edward W. Grant, Sr. 1651 ED WARA PM 12 Medical 12 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University OF MARYLAND Medical Center BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 214-54-4592 1 X M 2 □ F 12 02 51 MD 10a, State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21223 1 South Fulton Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland 12th grade 5ys+ Supervisor Be 17. Father's Name (First, Middle, Last) it. Page 1 and 2 should be filed rtment of Health and Mental H rtant: If item 27 is marked of njury or other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) Edwin Grant Dolores Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South Fulton Ave, Baltimore, Md 21223 Sondera Grant-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 CCremation 3 Removal from State 4 Donation 5 Other (Specify) 12/17/2012 Baltimore, Md Metro 21 Signature of Funeral Service Licensee March Address of Facility t Rome 4300 Wabash Ave, Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of) Approximate Interval Between Onset and Death Physician, Medical Due to (or as a consequence of): Éxaminer I MONANY embolus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last 13 ACTEREMIA Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 🖾 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation М 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sorth Greene ST BAHMORE MD Christophen Melinostry 31. Date filed (Month, Day, Year) 32 Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ reer Decembe 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death pkins Ho HOSPITAL timore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months Director 215-62-0806 1**X** M 2 □ F 58 Nov. 2, 1954 Maryland 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Talbott Md. Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 116 Talbott Lane, 21601 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. <u>ک</u> 1 X Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Yes. Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. 1972-1973 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٩ Briggs Walter Green, Sr. Annie Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1 and 2 s of Health a item 27 i 4210 Red Haven Road, Pikesville, Maryland Carmellita Green - Sister Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a Department of I Important: If ite eny Injury or of 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fastern Shore Veterans Cem. 12-28-2012 Hurlock, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor, II Funeral Home 108 W. North Avenue, Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician HEPATO CELLULAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the ettending physician and ched for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the e should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No this certificate After this certific funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဍ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fun Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Baltimore, MD.21287 KAUSTURHA MD

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month. Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 5:20 РМ Daniel Howard Gerhart December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lutherville-Timonium Baltimore Stella Maris If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Director 212-62-8573 1 X M 2 □ F Usual Residence of Deceden 59 Aug 7, 1953 Maryland or than "netural", or items 23a or 28e-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Forest Hill MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 United States 237 Melrose Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 Divorced Specify: Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Security Officer Warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked of 2012 ၉ Delmar Gerhart Helen Regina Fitch Homer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 and 2 sh Department of Health ar Importent: If item 27 is eny injury or other treu 237 Melrose Court Forest Hill, MD 21050 Ayres / Wife Brenda Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State DECEMBER 4 Donation 5 Other (Specify) Final Journey Crematory 12/20/2012 Woodbine, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 MO1251 23a. Part 1. Enter the prease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart foliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition END STAGE LIVER DISEASE Medical resulting in death) Due to (or as a consequence of) . Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 signed by the ettending d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery **GERHAR**¹ 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, DANTEL 1 Tes 3 Probably 4 Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) of Vital Other: 4 \square Nursing Home 5 \square Residence 6 K Other (Specify) HOSPICE 1 Tes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending Division n 24 hours after death.

• Funeral Director: Af Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title use of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, TIMONIUM, MD 21093 32. Registrar's gnature 31. Date filed (Month, Day, Year) 2012 State

M DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 0 | 2 State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 18, 2012 Physician/ GRACE T. HITTLE 6:40 PM Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner N/A GOOD SAMARITAN NURSING HOME BALTIMORE CITY 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖾 F 1472371926 MARYLAND 86 Director 217-24-1926 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🛛 No RIDGELEIGH BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 8514 WILLOW OAK ROAD 21234 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc 1 🗋 Never Married 2 🗆 Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r 12TH GRADE (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIRGINIA THOMAS ပ EDWARD SCHMIDT permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5926 WOODVILLE RD. MT AIRY, MD 21771 EARL E. MASON/SON Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE CEMETERY BALTIMORE, MD 12/22/2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO21 TOWSON, MD 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

Meta static Colon Cancer Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami signed by the attending physiclan and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? After this certificate has funeral director, page 2: 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Other: 1 Yes 2 No ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 - Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 18, 2012 158570 stem 23a) (Type, Print) L Raven Blad 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Baker MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 1 2012 Registrar

State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Year Q45/Am GARET HARIG DEC 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death verna Park Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Country) Maryland 05/07/1924 219 16 4112 88 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 🗆 Yes 2 🕅 No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1252 Rock Hill Road 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paralegal Law Office 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Clarence Councilman Iva Board 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Bents / Daughter 1252 Rock Hill Road Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Park 12/21/2012 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or shock, or heart failule. List of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death only one cause on each line. Immediate Cause (Final Physician/ montio disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner rukumu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) attending physician for use as the hurial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 1 | Yes 2 t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s performed' After this certificate 2 No 1 Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner's Other: ပ 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural Accident 1 Yes 2 No Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 908AM W. Hallums Ansel 2010 Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death Himorp Kaver Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) Director 250-44-6549 1 □XM 2 □ F 32 ŚC 01 19 80 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Baltimore NA 1X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 U.S.A. 3405 A Dolfield Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Mamied Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Mason and Dixon Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Shop Foreman 7th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil treent of Health and Mental rtant: If item 27 Is marked Azalee Nesbitt Sampson Hallums 19a. Informant's Name/Relationship (Type, Print)
Granddaughter
Jacqueline McCullough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 Prindle Drive, Bel Air, Md 21015 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tn once. Jacqueline Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore National 12/27/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee Markand Address of Facility 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter the diverse, or complications that cause should be a cause on each line immediate Cause (Final disease or and final cause or ano the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of) the attending physician and ched for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) signed by the at id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been signification cannot be care to be care and 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 To the Hospital or Attenuing Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41536 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ мчт2-19-2012 8:05A Joan R. Holy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8490 Byrd Road Pasadena Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Country) 212-34-0441 Director 1 □ M 2 🗓 F 76 April 03 1936 MD er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director Maryland Anne Arundel 1 Yes 2X No Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8490 Byrd Road 21122 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married <u>چ</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) General Manager Coffee Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be file alth and Mental H 27 Is marked of ir traumatic ever ည Roy Harvey Ritter Anna Dehn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 so of Health a f item 27 I Charles M. Brown 8490 Byrd Road, Pasadena, MD 21122 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any Injury or o Dec. 2012 24 1 Burial 2X Cremation 3 Removal from State Metro Crematory Inc. Baltimore, MAryland 4 Donation 5 Other 21. Signa rum Full 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the shock, or heart failure. List only Immediate Cause (Final ung ancer Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the attending physician and the for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 1 Yes 2 Ug Unknown g Unknown Hospital or Attending Province.

124 hours after deeth.

For Funeral Director After this certificate has been signed by the Funeral Director After this certificate has been signed by the Funeral director, page 2 should be detaction. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{E}\) Residence 6 \(\sum \) Other (Specify) 2 🗹 No 2| 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tipe of certifier 29d. Date signed (Month, Day, Year) 2012 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 205 HOSPITAL Dr Glen Burnie

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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that the	a ba axacuted	声득	Ilcal Examiner	Cause (Disease or that initiated event resulting in death)	injury	c. Petiph Due to (of as a	a consequ	uence of):	yada		disea	Je					Y20	ry.
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C	DOX a death o	bean signed by tha attanding physic should be dateched for use as the br	Physician/Medical	23b. Was decedent in the past 12 i 1 Yes 2 9 Unknown	months? ☐ No	1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	al death	3		ту				23d. Da Mo	te of delive	ry Day	Year
9	Jo, T.C.	signed b		Part II. Other signif	ficant conditions	contributing to death b	ut not res	sulting in the	0	Λ	en in Part	l. 				ibute to th		of death?
	DIVISION OF VILLAN DECOLOS, tal or Attending Physician: The lew requires	e has baar aga 2 shou	Completed by	Hyperten	sion, At	rial Fib.	ullat	ion;	Clos	tuid	ium			s an opsy formed?	!	onor to cor death?	npletion	ngs available of cause of
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7.77	hysici	his ca al dirac	မ	1 ☐ Yes 2 √	No				itient 3 🗆 D	OA Othe	er: 4 □ N	ursing Ho	me_5 🗌 Res	idence	6 ☐ Oth	er (Specify)		
	ndlng R	eth. r: After na funar	icate	27. Manner of Death 1 X Natural 2 Accident	5 Pending Investigation			28b. Time injur		28c. Injury work 1 🔲			28d. Describe	how inju	ury occum	ed		
	JIVISIO	s aftar da I Directo Id In by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined		iry - At ho c. (Specify	ome, farm,	street, factor	y, office			28f. Location City or To			er or Rural	Route N	umber,
•	e Hospital or	within 24 hours aftar daeth. To the Funeral Director: After this cartificate has complately filled in by the funeral director, page 2 complately filled in by the funeral director, page 2.	Medical	(Check 2		ysician: To the best of niner: On the basis of earse Practitioner: To the	xamination	n and/or in	vestigation, in	my opinio	n, death o	ccurred at	the time, date	and place	ce, and due	e to the cau	se(s) and	d manner stated.
	To th	withir To th	2	29b. Signature and		0. 0 1.	1 0	1001			number	ис ана ри	cc, and dde to			(Month, E)
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1				Dr. Ra	Al Raf	completed cause of d	Si	nai	e, Print) Haspi	tal	G		nllim	cu	2			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMONIUM If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 1 M 2 F Usual Residence of Decedent or 28a-f show parmit. Pega 1 end 2 should be fillad within 72 hours aftar daeth with tha Maryland Dapertmant of Haelth and Mantel Hyglena. Important: If Item 27 is marked other than "natural", or itsms 23a or 28a-1 show any injury or other traumetic event, the Madigal Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ✓ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Chatham Rd Funeral 21215 115 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married <u>중</u> 1 ☐ Yes 2 No If Yes, Give Year or Dates Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ondary (0-12) College (1-4 or 5+) Boyto. City 8 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) မ 5518 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Hve. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Dogation 5 Other (Specify) of Funeral Service Licensee 21. Signatur 22. Name and Address of Facility GaryP. March FH 270 Fredhilton Pass Balto MD 21229 fait / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inch, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm date Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). To the Hospital or Attending Physicism: Tha law raquiras that the daath cartificata ba axacuted within 24 hours after deeth.

To the Funeral Director: After this cartificata has baan signad by the attending physician and complataly filled in by the funeral director, page 2 should be datached for use as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 🔲 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 2012 of death (Item 23a) (Type, Print) 30. Name and 7300 JULA 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death HOWE Month Year Physician/ stiane December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins Johns Itimore Hospital **Baltimore City** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Year) Days Director 212-17-3152 1 □ M 2 👿 F Jan 9, 1953 laur 1+105 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County er than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 No MD **Ellicott City** Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11678 Laureloak Ct. 21042 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?/
1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7/ Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than ' any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Comptroller Own Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marie Anne Olla Louis Tristan Prosper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11678 Laureloak Ct. Ellicott City, MD 21042 Paul W. Howey 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dec 20, 2012 Glen Burnie, MD Atlantic Crematory, LLC Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 9 | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b autopsy 1 Yes 2 🗌 No Be (25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: ပ္ 1 ☐ Yes 2 ☐ No 1 Department 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie December ause of death (Item 23a) (Type, Print) and address of person who comple 101 Orleans St. Baltimore MD 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

arks

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onald Hammo		State of Maryland / Department of Health and Men 1-For State Certificate of Death		2012 41540
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death
Medical Exami	ner	Ronald Wayne Hammock Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of the	Month December	17, 2012 1756 hrs
		Baltimore Washington Medical Center Glen Burnie	0, 504	Anne Arundel
Funeral Director		212-11-4625 1 M 2 F 27 Yrs. Months Days Hours		(MM/DD/YYYY) 9. Birthplace (State or Foreign Menty)1and
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
vfaryland 28a-f show i at once.	ь	MD Baltimore Halethorpe		1 Yes 2 No
r 28a-	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Country?
with the Maryland ms 23a or 28a-f sho be notified at once		2924 Flordia Ave. 21227 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Control Original Control Original Control Original Control Original Control Or	gin? (Specify Yes or No-	USA 14. Race - American Indian, Black,
death	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican 3 Widowed 4 Divorced or Dates: If Yes, Specify Cuban, Mexican 1 Yes, Specify Cuban, Mexican 1 Yes, Specify Cuban, Mexican 1 Yes, Specify Cuban, Mexican		White, etc. Specify: White
hours natur Exam		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		16b. Kind of Business/Industry
D36 thin 72 ne. than	Completed	11 General Wor	`k	Retail Shipping
15-0 illed wi Hygie d other			's Name (First, Middle, Ma	,
21215-0036 uld be filed within 72 hours after Mental Hygiene marked other than "natural", c event, the Medical Examiner	To Be	Ronald Wayne Hammock Sr. Tra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num	ncey Marie Bander Bander Burner	
more, MD 21215-0036 Pages I and 2 should be filed within 7 lent of Health and Mental Hygiene. int: If item 27 is marked other than or other traumatic event, the Medical		Ronald Wayne Hammock Sr./ Father 2924 Florida Ave.		
S l an of Hea		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
		4 Donation 5 Other Specify Metro Crematory	12/20/12	Baltimore, Maryland rk Funeral Home
Balti permit. Departir Imports				e, Maryland 21229
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c failure. List only one cause on each line.		Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Narcotic (methadone) Intoxication Due to (or as a consequence of):		Death
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	Examiner	Co. (Disease or injury that initiated experts resulting in death). Last Due to (or as a consequence of):		
outed nd transit		d		
50, te be executed sysician and burial - transit	Redical	X AMENDED #1 as noted, 23a, 27, 28a-f, per #28d-f, per me, g936 2-27-13	r me,g936 2- SM	
Box 68760, e death certificate be the attending physic ed for use as the bur	M/m	IF FEMALE: 23b. Was decedent pregnant in the 1 Live high	c pregnancy	23d. Date of delivery Month Day Year
tox 6876 eath certificate at tending phy for use as the l	Physician/N	Pregnant at time of death 5 Other (Specify)		
के कि कि	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 23e. Did tob	pacco use contribute to the cause of death?
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ords w requi is been should	plete		24a. Was ar autops	y prior to completion of cause of
Rec The la icate hz page 2	Completed		perform 1 ✓ Yes 2	
of Vital Records, sg Physician: The law requir After this certificate has been s meral director, page 2 should	æ	25. Was case referred to medical examiner? 4. A local part of the spital		Residence 6 Other:
of Vil ing Physic After this tuneral dir	5	1 ✓ Yes 2 No IIII Inpatient 2 ✓ ENOutpatient 3 USA 1 Control of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work		ow injury occurred
	atio	Natural 5 Pending Investigation fd 12-17-12 fd 17:15 pm 1 Yes 2 X	Ulikilowi	
Division To the Hospital or Attendit within 24 hours after death. To the Fuoeral Director: /	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, et (Specify) Friend's Home	or Town, Sta	
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and platformer) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		nd place, and due to the cause(s)
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.	OCME	29d. Date signed (Month, Day, Year) December 18, 2012
		So. Name and address of person who completed cause of death (Item 23a)	with FETTing	200011001 10, 2012
		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Str	reet, Baltimore, MD	21223
S Regis	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
DHMH 17 Rev 1/2		DEC 2 1 2012 June 5. April Original		
OCME 2006		ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20, 2012 Physician/ December 1 7:35 AM John Richard Johnson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery 5909 Empire Way 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) Director 1 🔀 M 2 🗆 F 283-30-3060 Yrs 1934 Dec 18, Ohio 78 Usual Residence of Decede or then "neturel", or items 23e or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20852 5909 Empire Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married <u>გ</u> within 72 hours efter Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1965–68 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) el Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) permit. Page 1 and 2 should be filed wit. Depertment of Heelith and Mentel Hygier Importent: If Item 27 is merked other ti eny injury or other traumetic event, the once. Federal Government 5+ Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Ethel Hunt Bovd Stephen Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 Montgomery Lane #350 Bethesda, MD 20814 / Trustee Nickel Ann 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/22/2012 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signatule of Funeral Service Licen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Physician/ disease or conditi resulting in death) Lung Cancer , Medical Due to (or as a consequence of): Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ettending physicien end for use as the buriel-trensit Hospitel or Attending Physicien: The law requires thet the deeth certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Month Pregnant at time of death signed by the eld be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵| 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has After this certificete 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🛭 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA funerel 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death erei Director: A filled in by the f 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nur Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) December 20, 2012 D62234 rson who completed cause of death (Item 23a) (Type, Print) Manish Agrawal 9707 Medical Center Dr. #300 Rockville, MD 20850

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Virginia Johnson Florence Ί8. 12:05p M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Harford Memorial Hospital Havre De Grace 8. Date of Birth
(Month, Day, Year)
March 15,1 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🗗 F Maryland Director 214-18-1282 91 Vrs 1921 Usual Residence of Decedent 28a-f shov 10a, State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Aberdeen 1 🗆 Yes 2 🗀 No 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21001 USA 222 Perryman Station Apr 309 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married than "natural", or 1 ☐ Yes 2 ☐ No Specify 3 XXWidowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev George Washington Anna Manetta Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , Plymouth, MN 55447 William Johnson - Son 19010 31st Ave. N 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗆 Removal from State cemeters, crematory or other place)
Meadowridge Mem Park 12/22/2012 Elkridge, Maryland Manation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 23a. Part 1. En et the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ 0 disease or condition resulting in death) Division of Vital Records, P.O. Box 68760 Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year 9 Unknown us certificate has been signed by i director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. within 24 hours after To the Funeral Dire Medical

State

29a Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

DHMH 17 Rev 7/2009

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month NANCY ESTHER JOYNER 8434 M DEC Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Howard County General Hospital Columbia 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 🗹 Months Hours 97 Director 80 Ĩ91 4. Usual Residence of Decedent or 28a-f show be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 😾 No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral Ridge Road 3004 N. Apt. H 211 21041 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No White If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Manager Mote1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Richard Holland Mamie permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8809 Cardinal Forest Circle, Laurel, MD 20723 Nancy Jane Horrom Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place) Beahm's Chapel Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-20-2012 Luray, Virginia 22. Name and Address of Facility Metropolitan Funeral Service ure of Funeral Service/sicenses 5517 Vine Street, Alexandria, VA 22310 Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY FAILURF disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a nonsequence of sician and burial-transit COPD requires that the death certificate be executed ADVANCED Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown FIBRILLATION been signatures 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed certificate I 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street.and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29 c. License number 29d. Date signed (Month, Day, Year) NIRMAL KUMAR, FNU 0073857 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar FNU NIRMAL

31. Date filed (Month, Day, Year)

DEC 2 1 2012

DHMH 17 Rev 7/2009

CEDAR

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32. Registrar's Signature

KUMBR

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21044

12-09471 James Jones Ple

ease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	1 1 200 1
State of Maryland / Department of Health and Mental Hygiene 2012	41544
Certificate of Death	

		1- For State Certificate Registrar	e of Death	Reg. No.					
Physici Medical Exam		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year December 12, 2012	3, Time of Death 2110 hrs				
neulcai Exam		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		h h				
		1400 East Madison Street #809	Baltimore	N/A					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 216-34-8568 12 M 2 F 75	y) If Under 1 Year If Under 24Hr Months Days Hours Mir	Forei	Foreign				
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits				
A	اء	MD N/A Balt	timore		1 Yes 2 No				
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number	10f. Zip Code 9 2/205	10g. Citizen of What Cou	intry?				
eath with the items 23a o ust be notiff		11. Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (S	Specify Yes or No- 14. Race - Ame	rican Indian, Black,				
ter death	/ Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.) White, etc. Specify:					
iours af Latural Xamin	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	cedent's Usual Occupation (Give kind of ing most of working life. DO NOT use ref		/industry				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygien. 7is marked other than "natural", or items 23a or 28a-fab. wist event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) N/A	Driver	Baltimor	e City				
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be Co	James W. Jones Sr.	18.Mother's Nam Emma	e (First, Middle, Maiden Surname)					
D 21 should land Mer 7 is man	P	19a. Informant's Name/Relationship (Type, Int) 19b. N Gaybelle Comer-Cousin 140		Rural Route Number, Ci. or Town, Stat	e, Zip Code)				
nd 2 alth		20a. Method of Disposition 20b. Place of D	isposition (Name of cemetery, or other place)	Date 20c. Location - City o	Town, State				
P P P P		4 Donation 5 Other Specify: Arbit	us Mem. Park 104.	23/2012 Hale thory	e, MD				
Balt permit Depart Impor		Santte K. Ines	1101 E. North Av	e. Baltimore M	D 21202				
Physician	. //	23a. Part I. Enter the disease, or complications that caused the death. Do not enfailure. List only one cause on each line.		or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death				
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic C Due to (or as a consequence of):	ardiovascular Disease		Dead				
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			-				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated							
760, icate be executed physician and the burial - transit	al Ex	events resulting in death) Last Due to (or as a consequence or).							
60, ate be exemple obysician per burial -	Medical	UNPENDED AMENDED		Lood Day of different					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fueral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	cian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregn	23d. Date of delive Month	Day Year				
Box e death the atte	Physician	1 Yes 2 No 9 Unknown 9 Unknown		23e. Did tobacco use contribute to	the series of doubb?				
P.O.			the underlying cause given in Part I.	1 Yes 2 ✓ No 3 Pro					
ords, w require as been si should b	Completed by			autopsy prior to	utopsy findings available completion of cause of				
Reco The law cate has	omo;			performed? death? 1 Yes 2 No 1 Y	es 2 No				
Vital Recysiciso: The his certificate director, page	B	25. Was case referred to medical examiner? [Hospital: 4] legations 2 [FB/Output	26 Place of Death (Check atient 3 DOA Other Nursi	k only one) ing Home 5 Residence 6 ✔ Othe	er Scene				
Division of Vital Records, tat or Attending Physiciae: The law requirar at after death. Director: After this certificate has been is led in by the funeral director, page 2 should it.	n: T	1 V Yes 2 No 27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Tim	ne of Injury 28c. Injury at Work?	28d. Describe how injury occurred					
Sion Attendidated death.	catio	1 V Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm	1 Yes 2 No	28f. Location (Street and Number or R	ural Poute Number City				
Divisior Hospital or Attend 24 hours after death Foueral Director:	Certification:	3 Suicide 6 Could not be determined (Specify)	. Street, ractory, office building, etc.	or Town, State)	dial Notice Nations, Only				
To the Host within 24 hd To the Fuo completely (Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place, an stigation, in my opinion, death occurred	nd due to the cause(s) and manner as sta at the time, date and place, and due to t	ted. he cause(s)				
To the within To the compl	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Me					
		D-UL.	O.C.M.E.	December 20, 2	2012				
カン		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner	900 W. Baltimore Street, Balti	imore, MD 21223					
Segis	tate	31 Date filed (Month, Day Year) 32 Registrar's Signature	rand	-					

ORIGINAL

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		-	For State	State of Maryland		artment of I tificate of I			2.0	12 4	1545
			Registrar 1. Decedent's Name (First, Middle, La	st)		tincate of t	Deatri	2. Date of Dea	Reg. No.	3	Time of Death
	Physicia Medic		Benjamin	Jones				Month.	18	2012	4.30Tm
	Examin		4a Facility Name of not institution, give			4b. City, Town, o	r Location of Death		4c. Count	ty of Death	
-	Funeral		Olason's Hospi 5. Social Security Number 16. S		st hirthday)	Kandal If Under 1 Year	Stown If Under 24 Hrs.	8. Date of Birt	Ba	1timor	
	Director		ALT PLET	X M 2 □ F / :	Z Yrs.	Months Days	Hours Min.	(Month, Day		9. Birthplace Country)	(State or Foreign
	D WO		Usual Residence of Decedent 10a, State 10b. County	· · · · · · · · · · · · · · · · · · ·	<u> </u>			11/11//	948	L MD	
	arylan a-feh fled a	윷	A A D 4 // N		, Town or Lo						nside City Limits
	or 28	盲	10e. Street and Number		altim	10f. Zip Code			10g. Citizen of	f What Country?	1 163 2 1140
	1 and 2 should be filad within 72 hours efter death with the Maryland if Haalth end Mental Hyglene. It has the marked other than "neture!", or Items 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at	Funeral Director	2020 Willhelm	St.		2/2	23		USI	4	
	death r item		11. Mantal Status	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No		Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - American In ack, White, etc.	ndian,
336	s efter ei", o	d by	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.		I ☐ Yes 2 🕱 No	Specify:		Specif		
9	hours netur	Completed	15. Decedent's 8	Business/Industr	v 1						
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an	ild be file Mental narked c	힡	Benjamin Jon	s Sr.			18. Mother's Name	Queer		ne)	
Maryland 21215-0036	2 should Ith end M 27 is mar traumati		19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	and Number or Rura			State, Zip Code)
	1 and 2 soft Health item 27 other tre		Annie Vase - 1	10ther	2020		Um Sti	Baltino		21223	
Baltimore,	ge 1 a nt of F :: If ite or ot	П	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐			sition (Name of natory or other plac	ce)	Date		- City or Town,	State
ij	permit. Pege 1 Dapartment of Important: If it eny injury or o	Н	4 ☐ Donation 5 ☐ Other (Special Service Licen	ty) Day	VIEW (Chematol		March F	Baltin	ore, Mr)
B	Dapar Impor eny tr		Imette	K. mu		Name and Addre		Baltin	THEAS	1021202	
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the death						Арр	proximate
1	Pnysician		Immediate Cause (Final disease or condition	Luna	Car	1ds					erval Between set and Death
9	Medical Examiner	Ш	resulting in death)	Due to (or as a consequent	ence of):						·
		je	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):						
	outed and rensit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
	ba axecuted slcien and a burlal-trensit	cal E	resulting in death) Last	Due to (or as a consequent	ence of):						
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89	seth certificete attending phys i for use es tha	<u>Z</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 Live Birth 2 Fetal	ncy	le de la Servicia			23d. D	ate of delivery	
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Ö.	iet the dee id by the s detached	F)	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	ndertving cause gi	ven in Part I	23a Did to	phaces (see con	ntribute to the ca	use of death?
S, F	ires thet signad t ild ba det	d b		300 SAL 5AL 5A		, , ,			Yes 2 ☐ No		4 Unknown
ő	w require as been si 2 should	plete						24a. Was a		. Were autopsy fi	indings available
Records,	sicien: The lew certificete has lractor, page 2	Jom Jom						autop perfor	med?	prior to complet death? 1 \(\sum \) Yes 2 \(\sum \)	tion of cause of
ā	clen: ertific actor,	Be	25. Was case referred to predical examiner?	Hospital:			lace of Death (Check		2 62 110	1	
Ž	Physical direction	6	1 Yes 2 No	1 Inpatient 2 I	ER/Outpatier 28b. Time of		4 L Nursing Ho				, -(
Division of Vital	Attending Physicien: The lew requires thet the deeth certificate r daeth. r daeth. sctor: After this certificete has been signad by the attending phy by the funaral diractor, page 2 should ba detached for use es the	icate	1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Year)	injury	work	yan k? Yes 2 □ No	28d. Describe h	ow injury occui	леd	
Visi	or Atterda iterda irecto n by th	ertif	3 Suicide 6 Could not to 4 Homicide determined		ne, farm, stre	eet, factory, office		28f. Location (S City or Tow		ber or Rural Rout	te Number,
Ö	Hospitei or 24 hours afte Funerel Dir stely filled in	cal	29a. Certifier 1 Certifying Phy								
	To the Hospitei or Attend within 24 hours after deet To the Funerel Director: / completely filled in by the	Medical Certificate:	(Check 2 Li Medical Exam	sician: To the best of my knowled iner: On the basis of examination se Practitioner: To the best of m	and/or invest	igation in my opinio	on death occurred at	the time date a	nd place, and di	up to the course(e)) and manner stated.
	Withi To the		29b. Signature and title of certifier	Xh		29c. Licens		-		ed (Month, Day, 1	·-·
	2		· Coar	DIL			158/	7	Dec	19 20	12
	7		30. Name and address of person who	completed cause of death (Item	23a) (Type, P	Print)	Lu	13/-	dalo	· Pro	21061
	Stat	Œ	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure d	1	100	710	276	7 - 781	110

12-09492 James Jones, Sr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 41546

		1- For State Registrar	Certif	ficate of i	Death	Re	eg. No.	
Physicia	ın/	Decedent's Name (First, Middle, Last)				Date of Deat Month	Day Year	3. Time of Death 1414 hrs
ledical Exami	ner		nes, or	- Lab	. City, Town, or Location of	December	13, 2012 4c. County of Death	
		4a. Facility Name (if not institution, give s Saint Agnes Hospital	reet and number)	40	Baltimore	Death	Al/A	'
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year If Under	24Hrs. 8. Date of Bir		thplace (State or
Director		0.1-	2 F 80	Yrs.	Months Days Hours	Min. 11/30/1	O 2 7 Foreig	untry) N. C.
	ŀ	Usual Residence of Decedent	<u>''</u> 00	110.		1195071	754	14.01
any		10a. State 10b. County	10c. City, To	wn or Locatio	1			10d. Inside City Limits
laryland 28a-f show at ouce.	5	MD Baltime	re Du	undal	K			1 Yes 2 No
Maryland 28a-f sho d at once.	Director	10e. Street and Number			10f. Zip Code		og. Citizen of What Coul	ntry?
h the ?		4 Robinson Av	le		21220		USA	
th wit	uneral	11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?		Decedent of Hispanic Origin s, specify Cuban, Mexican, F		- 14. Race - Ameri White, etc.	can Indian, Black,
er dea	正	3 Widowed 4 Divorced If	Yes 2 No	1 ,	res 2 No specify:		Specify: Bla	ck
urs aft tural	ğ		Dates:	Sa. Decedent's	Usual Occupation (Give kin		16b. Kind of Business/	ndustry
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	et of working life. DO NOT us	se retired)	Eastern	61 1
5-0036 iled within 72 Hygiene. I other than	Completed	10th	N/A	Un	ine Operati	OF	Stainless	Steel
1215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. sarked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)				Name (First, Middle, I	vlaiden Surname)	
D 2121 should be fi and Mental I 7 is marked	To Be	19a, Informant's Name/Relationship (Type	nes Print)	19th Mailing	Address (Street and Numb	er or Rural Route Num	ber, City or Town, State	Zip Code)
and sho	7	Glorious Wooter	- Sister-In-Law	+727	New Pittshur	a Ave. Ba	Himore, M	1/2/222
e, and and Healt item	1	20a. Method of Disposition	20b. Plac	ce of Disposit	on (Name of cemetery,	Date	20c. Location City or	Town, State
Baltimore, permit. Pages la Department of He Important: If ite injury or other t		Burial 2 Cremation 3 4 Donation 5 Other Specify:	Kellioval Ilolii State	insville	Complety	2/27/2N2	Crownsville	. un
Baltir permit.) Departm Imports injury or	ı	21. Signature of Funeral Service License			me and Address of Facility	March	FlH-East	
E F P E	- 7	Fynette K	me)	1101	E. North AV	e. Baltin		202
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each	itions that caused the death. Do line.	o not enter the	mode of dying, such as car	diac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
xaminer	- 9		Complications e to (or as a consequence of):	of Dia	betes Mellit	ıs		Death
		h	e to (or as a consequence or).		*			
	Ē	Sequentially list conditions, if any, leading to immediate Ducause. Enter Underlying Cause	e to (or as a consequence of):					
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ecuted and - transit		d.						
al an	Medical	X UNPENDED X	MENDED 23a, pt. #19b.perFH.	II , 2	7 per me g93 0/24/2013.WS	66 2-27-13	vt	
760, ficate be g physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnar	ncy			23d. Date of deliver	/ Day Year
Box 687 death certific the attending of for use as the	ciar	past 12 months?	Live birth Pregnant at time of death		I death 3Ectopic p er (Specify)	negriancy	I WOTER	suy rou.
BO) e death the att	Physician/	1 Yes 2 No 9 Unknown	9 Unknown					
P.O. s that the	by P	Part II. Other significant conditions					obacco use contribute to	
S, P.C.		Hypertensive At	herosclerotic	Cardi	ovascular D1	sease 24a, Was		itopsy findings available
Records, The law require ficate has been si	Completed					autop		completion of cause of
ial Rec	E					1 Yes		es 2 No
tal Recian: The	Be	25. Was case referred to medical examiner?	pital: 1 Inpatient 2 🗸 EF		26.Place of Death (C	Check only one) Nursing Home 5	D :: 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
of Vital ng Physician After this certi	۴	1 ✓ Yes 2 No 27. Manner of Death	· · · · · · · · · · · · · · · · · · ·	Bb. Time of Inj			Residence 6 Othe	
ading Pl th. : After e funera	ö	1 X Natural 5 Pending	(Month, Day, Year)		1 Yes 2 N	i i		
Division tal or Attendi rs after death.	icat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	e, farm, street	factory, office building, etc.		Street and Number or Ru	ıral Route Number, City
DIVI ppital or ours afte teral Dir filled in	Certification:	3 Suicide 6 Could not be determined	(Specify)			or Town, S	State)	
		29a. Certifier 1 Certifying Physician	To the best of my knowledge,					
To the Hos within 24 h To the Fur completely	Medical	a	n the basis of examination and/ nd manner stated.	or investigation		urred at the time, date		
	Σ	29b. Şignature and title of certifier	A	(1)	29c. License number O.C.M.E.		29d. Date signed (Mo	
		10/11	MAA	MI	U.C.IVI.E.		December 14, 2	V 12
10		 Name and address of person who cor Zabiullah Ali, M.D. Assista 	npleted cause of death (Item) 23 ant Medical Examiner		altimore Street, Baltin	nore, MD 21223		
St	ate	31. Date filed (Month. Day, Year)						
Regist		DFC 2 1 2012	Venera B.	fork				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 930AM Gregory Thomas Kobal 12 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rosedale Saucere Hospilal Baltimore FRANKLIN If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Social Security Number 8. Date of Birth Days Hours (Month, Day, Year) Director 220 66 0401 1 ☑ M 2 ☐ F 54 Nov.30,1958 Maryland Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heelih end Mentel Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Madical Evantiner must be notified at ury or other traumatic event, I'm Madical Evantiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104 Bladen Rd. 21221 **USA** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 💆 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Basil Kobal Jr. Ruth Margo McHaffie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Margo Kobal (Mother) 104 Bladen Rd. Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any Injury or once. Oak Lawn Cemetery 12/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex W. om Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumon Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury Examine Due to (or as a consequence of): cate has been signed by the attending physician end page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ie Hospital or Au... In 24 hours after death. In 24 hours after thi In the funer 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) C.M. celli W. 12/12/2015 D36663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Willes STUART 4000 FRANKLIN SQUARE DR Balto Md 31. Date filed (Month, Day, Year) 32. Pagietrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 11, 2012 Physician/ WILLIAM 7:30p M Α. KRAUSZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE BALTIMORE TIMONIUM Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) Days Min. (Month, Day, Year) 219-22-4966 Director 1 🗆 M 2 🕱 F 11/14/1928 84 MARYLAND 28e-f shov Department of Health and Mentel Hyglene. Importent: If Item 27 is marked other then "heturel", or Items 23e or 28e-f sho eny highty or other treumatic event, the Medical Examiner must han affiled at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No BALTIMORE **ESSEX** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 509 GEORGE AVENUE 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) REPAIRMAN ELECTRIC MOTORS Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be fill Iment of Health and Mentel tent: If Item 27 is marked o WILLIAM L. KRAUSZ ANNA HOHENSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY KRAUSZ/ WIFE 509 GEORGE AVENUE, ESSEX, MARYLAND 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEM. 12/14/12 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
LILLY & ZEILER INC.
700 S. CONKLING ST., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ESOPHAGEAL CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) After this certificate has been signed by the ettending physicien and funeral director, page 2 should be detached for use as the burlal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospitel or Attending Physicien: The lew requires that the death certificate be P.O. Box 68760 IF FEMALE: KRAUSZ 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 🕱 No |@ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Lirector: After this completely filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide injury work? 1 🗌 Yes 2 🗆 No 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 M Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature apd 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DEC 2 1 2012 32. Registrar's Signature Registrar

DECEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #19a Per FH G935 1/03/2013 JH State of Maryland / Department of Health and Mental Hygiene | 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PM Somerville Kinney 12 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore A And W Assisted Living If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. (Month, Day, Year) Director 212-28-5073 1 □ M 2X F bз 25 30 MD 82 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 □**X**es 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 U.S.A 812 Radnor Ave 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Citv Elementary/Secondary (0-12) College (1-4 or 5+) Pu<u>blic Schools</u> 12th grade 6vrs Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George C. Jefferson Alice Kinney 19a. Informant's Name/Belationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any Injury or other tra Spruill-Niece Radnor Ave, Baltimore, Md 21212 Syreta 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/22/2012 Baltimore, Md 4 Donation 5 D Other (Specify) Cedar Hill of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart Enysician/ Congestive years disease or condition Medical resulting in death) Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 KNo
9 Unknown Month Day Year signed by the at 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should it. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted 2 No Hospital: Other: 4 Nursing Home 5 Residence မှ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 A Other (Specify) 27. Manner of Death

1 Natural
2 Accident
3 Suicide
4 Homicide 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven Blvd, Baltime MD 21239 RMB 500 5601 MD 37. Registrar's Signatu 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ 2:05 PM December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Homewood of Frederick Frederick If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Sept. 14, Months Days Hours Min 1 □ M 2 💢 F New York 1915 091-38-7211 97 **Director** Usual Residence of Decedent or 28a-f show notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 🗌 Yes 2 🕱 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21701 U.S.A. 7212 Fish Hatchery Road death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 1 ☐ Yes 2 🕅 No Black. White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 → Widowed 4 □ Divorced "natural" Completed Year or Dates al Hygiene. d other than "natura event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Public School Teacher permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ George Wilson Ethelyn Lyon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7212 Fish Hatchery Rd., Frederick, MD 21701 David Keech (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Moss Street Cemetery 12-27-2012 Town of Kingsbury, NY 4 Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 21. Sig ature of uneral Service L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence or; Cause (Disease or iinjury that initiated events resulting in death) Last Knowy to Physicians Ast Dorothy Keech attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months 1 Yes 2 No Day signed by the atte Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 CHO <u>-</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certificate: 1 Natural 5 Pending s after dea. Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours af

To the Funeral D

completed filled in To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Learning Nurse Practioner: To the best of my investigation, and the first place of the cause is an anomal and manner as stated (Check 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of 31. Date filed (Month, Day, State 2012 DEC 2 1

Registrar

Jessia 4 12-05874	101		es Are Leg	ible.	41551						
UNK UNK		State of Maryland / Department of Health and Mental F-For State Certificate of Death	lygiene Reg		41001						
2-5883 Physicia Medical Examin	n/	legistrar 1. Decedent's Name (First, Middle,Last) Jessica Lynn Lee	2. Date of Death	Day Vear	3. Time of Death 1447 hrs						
Wedical Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Death							
Funeral		8139 Ritchie Highway Pasadena 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	rs. 8. Date of Birth	Anne Arundel (MM/DD/YYYY) 9. Birti							
Director	Ĺ	212 35 4601 _{1 M 2 X F} 20 _{Yrs.} Months Days Hours M	n. 12/17,	/1991 Foreign	n _{ntry} Maryland						
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
yland r-f show	핡	Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code	100	. Citizen of What Coun	1 Yes 2 No						
the Ma 3a or 28 otified a	Dire	5515 Magie Street 21225		U.S.A.							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1		14. Race - Americ White, etc.	an Indian, Black,						
s after de	ᇗ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Ework dono	Specify: W]	nite						
72 hours	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use re									
-0036 J within grene. ther tha	d mo:	10 Homemaker 17. Father's Name (First, Middle, Last) 18.Mother's Name	ne (First, Middle, Ma	Own Ho	ome 						
21215-0036 suld be filed within 7 Menal Hygiene. marked other than ic event, the Medica	Kenny Lee Ann Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow										
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ore, les 1 and of Healt If item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or							
Baltimore, ocrnit. Pages I a. Department of the important: If it in injury or other it.	-	4 Donation 5 Other Specify.	2/21/2012 Sonce Fund	eral Servic	e, Maryland e, P.A.						
លំ ឱ្យី១១ Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	way Bal	timore, Mar	Approximate Interval						
/Medical Examiner	'n	failure. List only/one cause on each line. Immediate Cause (Final disease a. <u>Multiple Injuries</u>			Between Onset and Death						
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.									
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uted Id ransit	ш	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
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6876 ertificate ding phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg	nancy	23d. Date of delivery Month D	ay Year						
Box 68760 re death certificate b the attending physical	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown		ĥ.							
ords, P.O. Box 68760, w requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial - transit	<u>S</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to to 2 No 3 Prob							
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Vital I hysician: this certifi	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other,4 Number 2	sing Home 5 R	Residence 6 🗹 Other	Scene						
nn of Nading Ph.	ion: T	27. Manner of Death 1 Natural 5 Pending 1 Natural 5 Pending 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 1 Yes 2 No		ow injury occurred : was assau	lted						
Division of Vital Records, P.O. Lad or Attending Physician: The law requires that the start cleath. *A Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach	Certification:	Accident Accident and Accident and Accident and Accident and Accident acci	or Town, Sta	reet and Number or Ru ate) near Rt .							
_ E S 5 E		4 X Homicide determined (Specify) Wooded Area 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	Pasaden	a,MD.							
To the Hos within 24 h Completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	d at the time, date a	nd place, and due to the 29d. Date signed (Mor	e cause(s)						
	-	Avail Author MA		August 7, 2012							
pend		30. Name and address of person who completed cause of death (Item 23a) Parmeta E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Ba	Itimore, MD 21	223							
St	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature									
Regist	TCT.	DEC 2 1 2012 June S. Jacks									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 41552

William Keith Lange State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1045 hrs December 14, 2012 çal Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Glen Burnie 403 Kent Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Social Security Number 6. Sex **Funeral** Foreign Country) Director 1 M 2 F MD. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 1 Yes 2 No 28a-f show ANNEARUNDE permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Impertant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transatic event, ithe Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10e. Street and Numbe 403 KENT RD 21060 Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Yes 1 Yes 2 No Yes, Give Year specify: 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 STATE GOVERNMENT RNEY COORDINATOR 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ERNEST ChRISTIAN LANGE ARMEN CHLOE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRETT LANGE, SADENAMO Z1122 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State 12-19-12 INVERCEMATORY Donation 5 Other Specify. 22. Name and Address of Facility DAUGNERTY FUNERAL HOME 21. Si nature of Funeral Service Licenses 2601 MOUNTAIN RD. PASADENA, MO. 2112-2 Approximate Interval cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician failure. List only one cause on each line. Between Onset and Medical Death a. Myocardial Infarction Immediate Cause (Final disease Éxaminer or condition resulting in death) Due to (or as a consequence of) h Atherosclerotic Cardiovascular Disease Sequentially list conditions, Duw to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED physician a he burial -AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the Vear 1 Live birth 3 Ectopic pregnancy Day use as Fetal death 2 past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Ischemic Cardiomyopathy, Heart Failure Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? certificate has performed? ✓ Yes 2 No 2 No page 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene After this 1 🗸 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of Injury 1 V Natural 1 Yes 2 No 5 Pending the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 | | 6 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier O.C.M.E. December 15, 2012 OUME 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Mary G. Ripple MD.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Market 2

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deal Physician/ 12:15+ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 220-20-1342 1 M 2 X F 84 07/31/1928 MD ntal Hygiene. ad other than "natural", or items 23e or 28e-f ahow event, the Medical Examinar must be notified at Pege 1 and 2 should be filed within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6822 PARSONS AVENUE 21207 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baitimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental F 27 is merked o treumatic eve မ **KENNY** CHARLES MARIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth Item 27 HEIDI REDMOND / DAUGHTER 1763 CHRISTIANA DRIVE, FINKSBURG, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 Depertment of Important: If it eny injury or o PROGRESSIVE RUDOMER 12/20/2012 1 X Burial 2 Cremation 3 Removal from State ROSEDALE, MD 4 Donation 5 Other (Specify) Soyaty SOL LEVINSON & BROS., INC. of Funeral Service Lice 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iliginy that initiated events resulting in death) Last Due to (or as a consequence of): Examir ettending physicien and if for use as the buriel-transit the Hospitel or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month signed by the et id be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 3 Probably 4 Unknown After this certificete has been a funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No To Be 25. Was case referred to predical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: Aft completally filled in by the fu 2 Accident
3 Suicide Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) he and address of person who completed cause of death (Item 23a) (Type, Print) D

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 17, 2012 3:03 LOHR VIRGINIA LORETTA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) . Birthplace (State or Foreign Country) Funeral 227-09-7678 1 □ M 2 🖺 F 98 Director Dec. 28, 1913 Virginia 27 is merked other then "neturel", or Iteme 23e or 28e-f show treumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Suitland Prince George MD 1 ☐ Yes 2 X No 喜 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 4901 Eastern Lane within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 7 and Mental Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) High School Cafeteria Food Preparer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Magdelene Price Robert Lee Lindsay 1 and 2 should b of Heelth end Mei item 27 is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20602 801 Roxbury Ct., Waldorf, MD Shirley L. Salo Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Depertment of F
Importent: If ite
eny Injury or ott 20c. Location - City or Town, State 1 Removal from State cemetery, crematory or other place) 4 Donation 5 D Other (Specify) Walker's UMC 12-22-2012 Madison County, VA 22 Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., ALexandria, VA 22310 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Privsician/ disease or condition resulting in death) Medical Éxaminer mon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events s a consequence of end i-transit Exami or Attending Physicien: The lew requires that the deeth certificete be executed Due to (or as a con resulting in death) Last attending physicien e for use es the buriei-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month signed by the a 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospitel or Attending Physicien: The lew requires within 24 hours after death.

To the Funerel Director: After this certificete hes been sit completely filled in by the funerel director, pege 2 should ' 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation ☐ Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) December 18 2012

121

Registrar
DHMH 17 Rev 06-2011

7503 Surratts Road, Clinton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrats Signature

Hassan Calaf, MD

31. Date filed (Month, Day, Year) DEC 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 Month Physician/ 12:40 AM Lambert Mary R. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Roland Park Place N/A Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours 220-44-9107 Director 1 M 2 StF 98 Dec. 6, 1914 New Jersey 27 in marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State death with the Maryland Director N/A 1 Yes 2 No Baltimore MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21211 USA 830 W. 40th Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Black, White, etc. <u>م</u> 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: specify White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: if item 27 is marked out any Injury or other traumatic event 2008. Mary McGrann Rudigier Edward A. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3126 Golf Course Road West Owings Mills, MD. 21117 Barbara Hart/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Co. 12-20-12 Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fune Service Licen-1050 York Rd. Towson, MD. 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea Immediate Cause (Final Heart Physician -ongestive disease or condition resulting in death) Medical Due to (or consequence of): Examine unknown Atrio-ventricular Sequentially list conditions, if any, leading to immediate cause. (Discount or initial control of the control o Examine Diju to (or as a nonsequence of): Fibrosis To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The lew requires that the death certificate be executed ulmonar Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mass Right Breast 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 6 1 Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 2 🖾 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manger of Death 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 1 🖾 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of coni 29d. Date signed (Month, Day, Year) December 19, 2012 42129 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6301 N. Charles Baltimare 21213 SH nclonnel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DEC 2 1 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

		1	State Registrar	Cer	tificate of Dea	ath	Reg. N	7111/	41556				
	Physicia	n/	Decedent's Name (First, Middle, Last) MILDRED F • MUELLER				2. Date of Death DECEMBER	74, 2012	3. Time of Death 12:00 P.M				
	Medic Examin		4a. Facility Name (if not institution, give street and number 2 DEMAREST COURT	per)	4b. City, Town, or Loca	ation of Death		4c. County of Death BALTIMORE					
	Funeral Director		258-28-5977 1 □ M 2 🖾 F	7. Age (In yrs. last birthday) 90 Yrs.			8. Date of Birth 6/30/1922	9. Birthp GEOR	lace (State or Foreign				
	Maryland 28a-f show otified at	I 1	Usual Residence of Decedent 10a. State 10b. County MD BALTIMORE	10c. City, Town or Loc				1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No				
	vith the 23a or 3	eral D	10e. Street and Number 9509 POWDERHORN LANE		10f. Zip Code 21234	4	10g. (Citizen of What Coun	try?				
336	e fled within 72 hours after death with the Maryland the Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ		2. K) No	Was Decedent of Hispar f Yes, specify Cuban, M I ☐ Yes 2 No St	nic Origin? (Specif lexican, Puerto Ri	y Yes or No- can, etc.)	14. Race - Americ Black, White, e Specify: WHI	etc.				
Baltimore, Maryland 21215-0036	ithin 72 hours ene. r than "natur the Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1- 11TH GRADE	16a. Decec (Give I life. D	dent's Usual Occupation kind of work done during O NOT use retired) RDRESSER	n g most of working		Kind of Business Inc	dustry				
nd 2	filed w al Hygi d other	Be	17. Father's Name (First, Middle, Last)	<u> </u>	18.	. Mother's Name (First, Middle, Maide	n S <i>u</i> ma <i>m</i> e)					
ryla	should be f n and Menta r is marked raumatic ev	JOHN F. NALLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State											
, Ma	2 sho than tran		JOHN A. F. MUELLER/SON	1.	PENN AVE.		RE, MD 2						
imore	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other	JOHN F. NALLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, John A. F. MUELLER/SON 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State defined by Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC. 12/19/2012 CATONSVII											
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service License MOO2.17		2. Name and Address of 5521 LOCH RA				RAL HOME, P 286				
	'hysician' Medical Examiner	Medical resulting in death) Due to las a consquence of): Examiner .											
89	sertificate be executed ding physician and use as the burial-transit	n/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	or as a consequence of):			- 0.1	23d. Date of deliv	ery				
Box	he death certifi y the attending iched for use a	Physician/M	in the pact 12 months?	ant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year				
ls, P.O.	requires that the death certific been signed by the attending I should be detached for use as	þ	Part II. Other significant conditions contributing to de	eath but not resulting in the t	underlying cause given i	in Part I.		o use contribute to the 2 X No 3 □ Pro	ne cause of death?				
of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed					24a. Was an autopsy performed	prior to co death? No 1 \(\subseteq \text{Yes}					
/ital	/sician: s certifical	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ☐ ER/Outpatie	Othor	of Death (Check of		DAUGH 6X Other (Specify	1				
on of \	ath. ath. r: After this	Certificate: T	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation	f 28c. Injury at		3d. Describe how in							
Division	tal or Atters after de al Directo ed in by the			of Injury - At home, farm, str ng, etc. <i>(Specify)</i>	reet, factory, office	28	Bf. Location (Street City or Town, Sta	and Number or Rura ate)	Route Number,				
	the Hospi thin 24 hou the Funer mpleted fill	Medical	29a. Certifier (Check only one) 3 Certifying Nurse Practioner:	is of examination and/or inves	stigation, in my opinion, d death occurred at the tim	death occurred at the ne, date and place,	ne time, date and pla and due to the caus	ace, and due to the ca se(s) and manner as si	use(s) and manner stated rated.				
	7 wit		29b. Signature and title of certifier	Ma	29c. License nui	7836	290.	Date signed (Month,	012				
	d Em		30. Name and address of person who completed cause (1912 Leaf Fund Note 1912)	5 10 0	Print) REDY,	MD Ltimre	MO	2123	4				
	Sta Registr		31. Date filed (Month, Day, Year) 32. R	egistrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b.perFH, G935, 1/2/2013, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Morrison lecein be Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Sinai Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month. Day, Year) Country) Director 213-36-4639 1 🛛 M 2 🗆 F Yrs. 80 13 39 SC 73 Usual Residence of Decede ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 A Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funera 21215 U.S.A. 5705 Simmonds Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?,

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiana. Elementary/Secondary (0-12) College (1-4 or 5+) Martins West Chef Grande Manager 2th grade na permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If Itam 27 Is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hattie Barno Leroy Morrison Ab Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5703 Simmonds Ave, Baltimore, Md 21215 19a. Informant's Name/Relationship (Type, Print) Joyce Marie Morrison-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 15 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/12 Woodlawn, Memorial Park King 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licentsee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) 21215 Approximate Interval Between Onset and Death Priysician/ 1 ELX mongar disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner monary Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Examine Durato (or as a consequence of): attanding physician and I for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last or Attanding Physician: The law requires that the deeth cartificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signad by tha at Id ba detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Records, icate has bean sig r, paga 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: Atter this certificate is completely filled in by the funeral director, page 1 ☐ Yes 2 ☑ No Yes 2 **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🛮 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending м ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ecomber/ use of death (Item 23a) (Type, Print) 30. Name and address of person who completed 2435W-37B-31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D18, 2012 4:15 P M December Doris Montgomery Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Casey House Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) (Month, Day, Year) Hours Director 579-44-8441 1 □ M 2 🖾 F Washington, DC 78 May 25. 1934 Usual Residence of Dece 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28e-f 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 'n 10g. Citizen of What Country? permit. Pege 1 end 2 should be filed within 72 hours after death with 1 Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "netural", or items 23e to provide the hinry or other traumetic event, the Medical Examiner must be once. by Funeral 628 Whitingham Drive 20904 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Antique Toy Dealer Antiques Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Marcus Ovid Cohen Josephine Lassin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerry Hoagland / Daughter 10307 Yellow Pine Dr. Vienna, VA 22182 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XI Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 12/21/2012 Woodbine, Maryland Signature of Funeral Service Licer 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Seosis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 XNo Day Pregnant at time of death Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) HOSpice 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending ☐ Accident ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗵 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signaty 29c. License number 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Debrah Miller

DEC 2 1

31. Date filed (Month, Day, Year)

Rockville, MD 20855

6001 Muncaster Mill Rd.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December 18, 2012 Physician/ 8:15 A M John Ryan MacKenzie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 121**–14–**1731 1 🛛 M 2 🗆 F Aug 25, 1923 New York 89 ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 X No Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20850 United States 14431 Traville Gardens Circle #409D 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. . Was Decedent Ever in U.S. Armed Forces? 1 1 ★ Yes 2 □ No If Yes, Give Year or Dates. 1942–65 Black, White, etc. "natural", or 1 Never Married 2 Married à Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Congressional Relations U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Grace Anne Ryan Α. MacKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14601 Snapdragon Circle N. Potomac, MD 20878 Susan Tendall / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If Ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/20/2012 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Betweer Onset and Death Immediate Cause (Final disease or condition Physician Dementia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) ed by the a Records, P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? autopsy Hospital or Attending Physician: The law
 24 hours after death.
 Funeral Director: After this certificate has 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA မြ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 8c. Injury at 28d. Describe how injury occurred Certificate; 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tiffe of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 12-18-12 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Debrah Miller

2012

31. Date filed (Month, Day, Year)

Rockville, MD 20855

6001 Muncaster Mill Rd.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Ma	aryland / Depa <i>Cel</i>	artment of He rtificate of De			giene 2 () Reg. No.	112	41560
Divisia	/	Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	-Year	3. Time of Death
Physici Medi		Curtis Roy Meadows				Decembe			8:00 AM
Exami	ner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L			4c. County	y of Death GOME	v
Funeral		11925 Bambi Court 5. Social Security Number 6. Sex 7. Agr	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h		place (State or Foreign
Director		232-72-7054 1 ⋈ M 2 □ F Usual Residence of Decedent	68 Yrs.	Months Days	Tiours I William	Dec 31			Virginia
and show	٥	10a. State 10b. County	10c. City, Town or Lo	ocation			,		0d. Inside City Limits
Maryla 28a-f otifilec	irect	MD Montgomery		Gaither	sburg				1 🗌 Yes 2 🔀 No
th the	a D	10e. Street and Number		10f. Zip Code	10		10g. Citizen of United		
ath wi ems 2 r mus	Funeral Director	11. Marital Status 12. Was Decedent B	Ever in U.S. 13.	2087 Was Decedent of His	panic Origin? (Spe	cify Yes or No-		ce - Americ	
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by F	Armed Forces? 1 □ Never Married 2 🔀 Married 1 □ Yes 2 🔀 If Yes, Give	No	If Yes, specify Cuban 1 ☐ Yes 2 🔣 No	, Mexican, Puerto	Rican, etc.)	Bla Specify	ck, White, e	
5-0036 ! hours afte "natural", o dical Exam	Completed	3 Widowed 4 Divorced Year or Dates.		dent's Usual Occupat				MIIT	
215-	a du	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	(Give	kind of work done du OO NOT use retired)	iring most of worki	ng	16b. Kind of B		
2121 within 72 /giene. ner than 't, the Me		12		omer Servi		_	Home B		ng
and e filed ntal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	_		re)	
Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event	Ι.	Charles Lewis Meadows 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street ar				State, Zip (Code)
		Kim Ann Metz-Meadows / Wif	1	5 Bambi Ct			g, MD 20		
ge 1 and of He in it of He in it is		20a. Method of Disposition 1 Rurial 2 Cremation 3 Removal from State		matory or other place)	Date	20c. Location	- City or To	own, State
altimore, mit, Page 1 and spartment of Hea sportant: If Item y injury or othe		4 Donation 5 Other (Specify)	Final Jour						Maryland
Baltimo permit, Page Department o Important: If any injury or	l į	21. Signature of Funeral Service Licensee	MO1251 B	2. Name and Address oing Home everly L.	Crematic Heckrott	n Servi	ice P.O. Clarks	Box VIII	784 MD 21029
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line		ter the mode of dying	, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
→ Ply iria V Medica		Immediate Cause (Final disease or condition resulting in death) a. Sinus	Cancer						Onset and Death
Examine		Due to (or as	a consequence of):						
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):						
scuted and -transi	Examiner	Cause (Disease or injury that initiated events c.	a consequence of):					$\overline{}$	
760 cate be executed physician and the burial-transit	edical E	resulting in death) Last Due to (or as	a consequence on.						
3760 ficate b g physi as the t	Aedi	d							
P.O. Box 68 that the death certifulned by the attending e detached for use a	Physician/M		2 Fetal death 3	Ectopic pregnancy	/			ate of delive	ery Day Year
Bo le deat the at	lysic	1 Yes 2 No 4 Pregnant a 9 Unknown	t time of death 5 l	Other (specify)			141		Day Tou.
P.O.	by Ph	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause give	en in Part I.	23e. Did t	obacco use con	tribute to th	he cause of death?
ds, quires en sign						1 🗆	Yes 2 □ No	3 🗌 Prol	bably 4X Unknown
COF law re nas be e 2 sh	Completed					24a. Was auto		Were auto prior to co death?	psy findings available empletion of cause of
Re		25. Was case referred to medical		00.01	ce of Death (Checi	1 🗆 Yes	2 X No	1 Yes	2 No
Vita /siciar s certii directc	To Be	examiner?	ient 2 ER/Outpatie	Other			dence 6 🗆 Oth	ner (Specifi	······································
Division of Vital Records, lal or Attending Physician: The law requires rs after death. al Director. After this certificate has been signed in by the funeral director, page 2 should b		27. Manner of Death 1 1 1 Natural 5 □ Pending (Month, Date of injuction) (Month, Date of injuctio		work?	at		now injury occur		
ttendi death. tor: A / the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ury - At home, farm, st	M 1 L	Yes 2 □ No	28f Location (Street and Numb	her or Rura	I Route Number,
Divis		4 Homicide determined building, et		noot, lastery, office		City or Tov		507	, ricato i tarribor,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 X Certifying Physician: To the best of (Check 2 Medical Examiner: On the basis of a	examination and/or invest	stigation, in my opinior	n, death occurred a	t the time, date a	and place, and di	ue to the ca	use(s) and manner stated.
the Pithin 2 the Formplet	Me	only one) 3 Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	ne best of my knowledge	e, death occurred at th		ace, and due to	the cause(s) and 29d. Date signs		
F ≥ F ŏ					7142		Decemb		
		30. Name and address of person who completed cause of d		Print)					-
		G. Coleman 1355 Piccard I			20850				
St Regist	ate rar	DEC 2 1 2012 Lever	ar's Signature		<u>.</u>				
								_	

12:45 pm DECEMBER 18, 2012 MILTON MACCUBBIN

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene																		
				For State Registrar		State	of Ma	aryland /		rtmen tificate			and M	lental Hy	gien Reg. N	20	12	415	61
		Physicia Medic		1. Decedent's Name	e (First, Middle		Richai	rd Maccul	obin					2. Date of De Month 12		ay 8	Year 2012	3. Time of E 12:45	
4		Examin	er	4a. Facility Name (if			imber)			4b. City,	Town, or	Location of			4	c. County		more	
Ì	and .	Funeral Director		Stella Mar 5. Social Security N 218-44-8	umber	6. Sex		e (In yrs. last bi	rthday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Bir (Month, Da 04/2	rth ay, Year) 1/194	4	9 Birth	nplace (State or ntry) Maryland	Foreign
3		and show	å	Usual Residence of 10a. State	of Decedent 10b. County			10c. City, Tov	vn or Loc	ation								10d. Inside City	/ Limits
ひょうとい		Maryla 28e-f	Funeral Director	MD		Harford						Bel A	4ir					1 X Yes	2 🗌 No
. 4		with the 23a or	aral C	10e. Street and Nur		and				10f. Zip	Code	2101	1.4		10g. C	Citizen of \	What Cou	•	
7		items items	Fun													e - Amer	ican Indian,	-	
ď	Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is merked other then "netural", or items 23a or 28e-f show with highly or other treumatic event, the Medical Examiner must be notified at once.	ted by	1 Never Married 2 Married 1 No Blac Blac Blac Blac Blac Blac Blac Blac										k, White	, etc. /hite				
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6	and	ntal H	To Be	17. Father's Name (First, Middle, L	,						18. Moth	er's Name	e (First, Middle			e)		
4	ary	nould the mark merk		19a. Informant's Na	ame/Relationsh	Milton Ma nip (Type, Print)	<u>iccubt</u>		b. Mailin	g Address	(Street a	and Numbe	er or Rura	N Route Number		Protani or Town, S	State. Zip	Code)	
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DECEMBER	oore	age 1 e nt of H t: If ite / or oth				3 Removal fro	m State		ery, crem	atory or o	ther place	'		Date	20c.		-	Town, State	
EC	altin	mit. Pe pertme portan / injun		4 ☐ Donation 21. Signature of Fu				Che	_	ke Cre Name an		y is of Facilit		0/2012		Ве	eltsvill	e, MD	
7	œ _	80 1 6 6		Dorota Ma		Daule	ic, Ju	ashall								413 Ba	altimo	re, MD 21:	203
	F	nysician/		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List o (Final	only one cause on	each line	the death. Do				g, such as FA/			rrest,			Approximate Interval Betw Onset and D	reen
1		Medical Examiner		resulting in death)		Due to	o (or as a	a consequence	of):										
		n #	iner	Sequentially list co if any, leading to in	nmediate	b. Due to	o (or as a	consequence	e of):										
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į	687	ertifice ding pt se as t	/Me	IF FEMALE: 23b, Was decedent		23c. If ves. o	utcome	of pregnancy											
	. Box 68760	To the Hospital or Attending Physicien: The law requires that the death cartificate be within 24 hours effer death cartificate be within 24 hours effer death this certificate has been signed by the ettending physici to the tuneral Director. After this certificate has been signed by the ettending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	in the past 12 1 Yes 2 9 Unknown	months? ☐ No	1 □ Liv	e Birth egnant at	2 Fetal dea t time of death		Ectopic p Other (sp		у					ite of deli onth		ear
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Mac	<u>Ş</u>	Physic rthis o	은	1 ☐ Yes 2 27. Manner of Deat			Inpatie	ent 2 ER/C	Outpatien Time of		Othe Bc. Injury	4 L.J N		ome 5 Res		Oth		m HOSP	CE
N	ouo	ending lath. ir: Aftel he fune	icate	1 Natural 2 Accident	5 Pendin	ng (Mo	onth, Day	, Year)	injury	м	work	? Yes 2. □	- 1	zou. Describe	now inji	ury occur	eu		
	Division	itel or Atte ins efter de el Directo led in by t	al Certificate:	3 ∐ Suicide 4 □ Homicide	6 ∐ Could determ	ined 28e. Plac		ry - At home, i :. (Specify)	farm, stre	et, factory	, office			28f. Location City or To			er or Rur	al Route Numbe	er,
MIL		the Hospitel of thin 24 hours of the Funerel D mpletely filled in	Medical	(Check only one)	Medical E Certifying	Physician: To the examiner: On the b Nurse Practition	asis of ex	xamination and	or invest	igation, in	ny opinio	n, death o	ccurred at	the time, date	and place	ce, and du	e to the c	ause(s) and man	ner stated.
1		당		29b. Signature and	title of certifier	rop	-CI	enp		29c	License	number	12		29d. [ate signe	d (Month	, Day, Year) 2013	
10				30. Name and addr		who completed ca ROAW , C	RN	eath (Item 23a)	(Type, P	rint)	PIC	27	17)	Du LNO		VAI	MON	PN 7	10012
1		Sta		31. Date filed (Mont			Registra	ar's Signature	bar	Les .	بمب	~)	<i>ل_ ب</i>	VU/TIVE	7	V/1 //	7	IM)	- 10
XI	DHM	Registr 4H 17 Rev 06-		U("A T .	ALL		12.								-			· -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41562 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:30 ам Bernard Mosner December 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Prince George's Renaissance Gardens - Riderwood Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Director 062-16-5603 1 X M 2 □ F Illinois 92 July 17, 1920 Usual Residence of Deced 10b. County 27 is marked other than "naturel", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Rockville 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 U.S.A. 15412 Bitterroot Way 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1942 -Black, White, etc. 1 Never Married 2 Married φ should be filed within 72 hours afti and Mental Hygiene. Is marked other than "naturel", 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates. 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Auditor/CPA Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Helen Eder Samuel Mosner 1 and 2 should be of Health and Meritem 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15412 Bitterroot Way, Rockville, Maryland 20853 Leslie Altschuler/Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportent: If ite
any injury or ot 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Grdns: 12/21/2012 Olney, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee 23a. Part 1. Enter 1. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hort failure. List only one cause on each line.

Immediate Cause 1 had disease or conditions. 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Betweer Onset and Death
9 Months Physician/ End Stage Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Éxaminer <u>Arteriosclerotic</u> Cardiovascular Disease 4 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burdal-transit Due to (or as a consequence of): Be Completed by Physician/Medical If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) ၉ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

13x1

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

State Registrar Julaine Harding,

NEC. 2 1

31. Date filed (Month, Day, Year)

CRNP,

32 Registrar's Signatu

DHMH 17 Rev 06-2011

3110 Gravefield Road, Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ December 1020 AM Charles H. Mundhenk 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Baltimore Washington Med. Ctr. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day 92 Maryland 215-03-0463 1 XM 2 □ F Feb. 13,1920 Director Usual Residence of Decede show 10d. Inside City Limits 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a, State with the Maryland Director 1 Yes 2 No Anne Arundel Severn MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21144 1406 Georgia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status ıral", or iten I Examiner ı med Forces Black, White, etc. þ 1 Never Married 2 Married 2 No 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 □ Divorced White "natural", Completed Year or Dates. 44-45 permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natu any injury or other traumatic event, the Medical lonce. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Postal Clerk 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NUNDHENK မ Virginia Miller Charles Mundhenk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1406 Georgia Avenue Severn, Maryland 21144 Sharon R. Hughes - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/21/12 Baltimore, MD Loudon Park Cemetery Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. Brown-4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEART Physician/ ongestive disease or condition resulting in death) Medical Due to (r as a consequence of **Examiner** Renal Sequerinary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 Nnpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera injury 1X Natural 5 Pending Investigation Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

OXI

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL DR Glen BURNIG, MD SHANON CAMPBELL

succe cent

32. Registrar's Signature

Medical

29a. Certifier

29b. Signature and title of certifie

DEC

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

R118455

29d. Date signed (Month, Day, Year)

12/17/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State	of Marylar					nd M	ental Hy	giene	012	41564		
			Registrar			Cer	tificate	of De	eath			Reg. No.	J. No.			
	Physicia	n/	Decedent's Name (First, Middle	, Last)							2. Date of Dea Month		Year	3. Time of Death		
	Medic	al	JoAnn Franci								Decemb		, 2012	8:10 A M		
	Examin	er	4a. Facility Name (if not institution,		mber)		4b. City, To	own, or Lo	ocation of	Death			ounty of Death			
!			Gilchrist Hosp		12 4 0	for mile the fact the relative the sales	Tot	wson	If Under 2	/ Ure I	8. Date of Bir		ltimor			
	Funeral Director		47-74 ST 141-75	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs.				Hours	Min.	(Month, Da		Cou	nplace (State or Foreign ntry)		
		Н	214-54-1063 Usual Residence of Decedent	1 LJ M 2 L&F	6	3 Yrs.					04/22/	1949	Ma	ryland		
	and show	៦	10a. State 10b. County		10c. C	ty, Town or Lo	cation							10d. Inside City Limits		
	Aaryla Be-f	Director	MD		В	altimor	e					1 🔯 ነ				
:	or 2	₫	10e. Street and Number				10f. Zip C	Code				10g. Citize	n of What Cou	intry?		
1	with with	era	5504 Hampnett	Avenue			21	204				U.S	.A.			
:	tem tem	Funeral	11. Marital Status		cedent Ever in U	.S. 13.	Vas Deceder	nt of Hisp	anic Origi	in? (Spec	cify Yes or No-	14.	Race - Amer Black, White			
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER Day 12, 2012 MARY RHEA POZNANIAK 9:08 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death EDENWALD TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 215-05-7970 1 M 2 XF 97 07/11/1915 MARYLAND Usual Residence of Decedent 28a-f shov Pege 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Sent: If item 27 is marked other then "natural", or items 23a or 28a-f shoury or other treumetic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE 1 Yes 2 XNo TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 SOUTHERLY ROAD 21286 S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **GEORGE FUCHS** MARY HEIM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS COLLIER/DAUGHTER SPRINGBLOOM ROAD, MILLERSVILLE, MD 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pege 1 Department of Importent: If it eny injury or o 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State MOST HOLY REDEEMER 12/17/12 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND 21. Signature of Fune 1 Service Licensee 22 Language Address LETTER INC. FUNERAL HOME 700 S. CONKLING STREET BALTO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of): ^{*}Examiner elmory Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): signed by the attending physiclen end d be detached for use es the burial-transit or Attending Physicien: The lew requires thet the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, cate hes been sig ; pege 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 0 1 🗌 Yes Other: မ 4 Datursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 D Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 201

Registrar

State

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Rd.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41566 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year **PLOSKON** ANNA 11:55 PM DECEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 213-36-6294 Director 1 🗆 M 2 🛣 F 89 12/8/1923 POLAND Usual Residence of Decedent 10a. State 10b. County Item 27 is marked other then "nature!", or items 23a or 28a-f sho other traumatic event, the Medical Examina must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A MD BALTIMORE CITY 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 S. CURLEY STREET 21224 USA filed within 72 hours after death val I Hygiene. I other then "naturel", or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Ś 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 8TH GRADE SEAMTRESS CLOTHING FACTORY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ၉ THEODORE DZUIBAK JULIA JACOB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Importent: If Item 27 Is any Injury or other trau 24 S. CURLEY STREET JADWIGA PLOSKON/DAUGHTER BALTIMORE, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of DULCANEY CONTAINER THE PROPERTY OF THE PROP Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **GARDENS** 12/24/2012 COCKEYSVILLE, 21. Signature of Funeral Service Licensee MOO217 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P. A 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ EK2 Melis Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami ettending physicien end I for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? É of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun. 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinating and/or investigation in much like the cause of examinating and/or investigation in much like the cause of the cau 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 2012 OW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARUES 6701 N. LON ; an M 32. Registra 's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MICHELLE FAVE PALMER 7:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 630 E. EGTH STREET BALTIMORE, MU 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. 215.78.6470 **Director** 1 M 2 WF 53 8.16.59 MD Usual Residence of Decedent and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the <u>Medical Examiner must be notified at</u> 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 128A 630 E. 29TH STREET 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) UNIVERSITY HOSPITAL MEDICALSECRETARY NIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEVITICUS WHITE SYLVIA M. DUNILAP Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCUS PALMER, SON COCKEVSVILLE, MD 21030 2 HONIEVBEE CT. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 12/24/12 HANJOVER, MD REMATION CTR. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
VAUGHTU C. GREENE FUNERAL SERV.
49.05 YORK RD BALTO, MD 21212 Signature of Funeral Service Licensee 110/55 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner INNG DISCASE 11. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 ☐ Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 D Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 ENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 INER 31. Date filed (Month, Day, Year) Régistrar's Signature State Registrar

ta no

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 41568 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Laxmiben Bhagwandas Patel 2012 Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14317 Gate Dancer Lane Boyds Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year) Country Director 218-49-1367 1 - M 2 X F 97 Usual Residence of Decedent India 10a. State or than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🕅 No Maryland Montgomery Boyds ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 14317 Gate Dancer Lane 20841 India 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: South Asian 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Should ba flad within 72 h and Mantal Hygiena. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should ba Department of Haaith and Man Important: if item 27 is marke any Injury or other traumatic Becharbhai Madhabhai Patel Hiraben Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Haridas Patel</u> Maryland 20841 4317 Gate Dancer Lane Boyds, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State December 4 Donation 5 Other (Specify) Arundel Crematory 22, 2012 Odenton, Maryland 21. Signature of Foreral Service Unensul 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ Onset and Death disease or condition Cerebral Vascular Accident Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and a burial-transit Exami or Attending Physician: The law raquires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s tha burial Physician/Medical Box 68760 as attanding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year signed by tha at d be detachad f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, Completed 1 ☐ Yes 2 💹 No 3 ☐ Probably 4 ☐ Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has b director, paga 2 s autopsy performed? Yes 2 No 1 Yes 2 No r: After this certifica าง funeral director, p of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 💢 No 은 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division To the Hospital or Attendin within 24 hours after death.
To the Funaral Director: Af completely filled in by the fu □ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 December 18, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman, MD 1355 Piccard Drive Rockville, Maryland 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

DEC 2 1 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EPPER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AN/STOWN HOSPITAL NONTHWEST If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) Director 523-40-0960 1 🕅 M 2 🗆 F 83 07/25/1929 POLAND ed other than "natural", or items 23e or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🕅 No BALTIMORE RANDALLSTOWN 10g. Citizen of What Country? 10e. Street and Number Funeral 21133 USA 8904 MAPLEBROOK ROAD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER FURNITURE Be Filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H 27 is marked of traumatic ever ٥ **EPHRAIM** FEFFER UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 sho Department of Heelth an Important: If Item 27 is any injury or other trau 8904 MAPLEBROOK ROAD, RANDALLSTOWN, MD 21133 SHIRLEY PEPPER / WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 12/20/2012 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licencee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ LSCHEMIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine and I-tran it The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burlel-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the at d be detached for 9 Unknown g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 NET/1 Tres After this certificate 1 Yes 2 JAK Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 I Ippatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendin within 24 hours after deeth.

To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 30. Name and address of person who come ted cause of death (Item 23a) (Type, Print) LANDO CONTANTO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1<u>6</u> Month Physician/ John Panas 2012 December 2:50 AM Medical 4b. City, Town, or Location of Death Burtonsville 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Holy Cross Rehab & Nursing Center Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 213-20-6462 1 X M 2 □ F 92 **Director** July 2, 1920 New Jersey Usual Residence of Decede 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Laurel Maryland Howard 1 ☐ Yes 2 🔀 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20723 8776 Susini Drive permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 3 College (1-4 or 5+) Elementary/Secondary (0-12) Insurance Agent Be 18. Mother's Name (First, Middle, Maiden Surname) Natalia Dmytriw Father's Name (First, Middle, Last) Thomas Panas ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Panas - Son 8776 Susini Drive, Laurel, Maryland 20723 item 27 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Gardens 12/20/12 Timonium, Maryland 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signature of Funeral Service I censee 7250 Washington Blvd., Elkridge, Maryland 21075 M01283 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease or complications that cause ly one cause on each line shock, or heart failure. List or Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical as After this certificate has been signed by the attending funeral director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No Yes 2 L 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? 2 No Other:

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed ours after death. reral Director: Aft filled in by the fur within 24 hours a To the Funeral C

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Certificate:

Medical

27. Manner of Death

1 Natural

2 Accident
3 Suicide

4 - Homicide

3 🗌

29b. Signature and title of certifier

29a. Certifler (Check

5 Pending

Investigation 6 Could not be

determined

State

00054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

9801 Georgia Arnu # 1-12 silveypring MDLoga

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12/18/12

29d. Date signed (Month, Day, Year,

& hogavilli Sunista

31. Date filed (Month, Day, Year) **IEC 2 1 2012** 32. Registrar's Signatu

Registrar

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Desember 15 2092 12:36Pw Physician/ Carole Noel Powell Medical 4c. County of Death Frederick 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 12/22/1959 1 □ M 2 🗗 F Director 220-64-4285 52 Usual Residence of Deceder i Hygiene. I other than "natural", or items 23e or 28a-f show vent, the Wedscal Evanniner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Frederick Thurmont MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 USA 17 W. Main Street, #3 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 Marmy
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No 3 Widowed 4 KDivorced White Completed rear or Dates. 1478-79 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Restaurant Manager 12 Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other treumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Patricia Bossert Frederick Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17 W. Main Street, #3, Thumont, MD 21788 Nickolas Powell / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 12/19/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner loi. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours affect death.

To the Funceriel Director: Affect this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months? 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident (Month, Day, Year) 5 Pending м Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of tertine 29d. Date signed (Month, Day, Year) 29c. License number

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DR. Manua 31. Date filed (Month, Day, Year)

2012

DEC 2 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month 16. 2012 Physician/ Ritter December Preston Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 3917 - 2nd Street 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 218 44 9646 Director 1 X M 2 🗆 F 66 Yrs Maryland 03/27/1946 Usual Residence of Deceden 10d. Inside City Limits an "netural", or Items 23e or 28a-f show Medical Examiner must be notified at 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21225 3917 - 2nd Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes Give Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 1,10 Hospital Security Guard Be filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 end 2 should be filed tment of Health end Mental Hy tent: If item 27 Is marked oth Carroll Lee Ritter Julia Marie Hays 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) York, Pennsylvania 17402 Alfred Ritter / Brother 1385 Karens Wav Importent: If item 2 eny injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 12/20/2012 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway nameroli complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complication shock, or heart failure. List only one cau 23a. Part 1. Enter the dis Onset and Death Immediate Cause (Final LON Physician/ disease or condition resulting in death) Medical Examiner 90 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physicien: The law requires that the death certificate be executed sicien and burial-trans Due to (or as a consequence of): resulting in death) Last attending physicien for use as the buria Medical P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 5 Other (specify) Pregnant at time of death the 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate has 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

DHMH 17 Rev 06-2011

State Registrar 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle-Last) 2. Date of Death Physician/ S Merc oran Medical Examiner Istown 10 If Under 1 Year 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) Funeral If Under 24 Hrs. Director 1 M 2 🗆 F 13 or 28a-f ahow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is merked other then "neturel", or Items 23s or 28s-1 show in Interventing the multiplication in the multiplication in the multiplication. 10b. County 10a. State **Funeral Director** 10c. City 10d. Inside City Limits Salti more ISTOWN 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21133 wad 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 1 Newer Married 2 Married 1 Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Completed 3 ₩idowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired 16b. Kind of Business/Industry and Second odary (0-12) College (1-4 or 5+) 8 17. Father Name (First, Middle, Name (First, Middle; Maiden Surnar a Law) Olumbia 20b. Place of Disposition (Name of **I** Date Location - City or Town, State wings Mills Burial 2 Cremation 3 Removal from State emetery, crematory 5. Other (Specify) torrest 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ Medical disease or condition resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lighty) Examiner Due to (or as a consequence of): inding physician and use as the burial-transit or Attending Physicien: The law raquires that the death certificate be axecuted that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month 9 Unknown 9 Unknown Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to dical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Resider 27. Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 🗆 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) 30. Name and address of person who comp filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16, Physician/ 20 1 2 11:00 PM December Trudy Rosenbaum Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Potomac Valley Nursing Home If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday, **Funeral** (Month, Day, Year, Nov 26, 1 1 M 2 X Months New York Director 111-22-3908 84 Jsual Residence of Deceden "natural", or items 23a or 28a-f show adical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Mexical 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 X No Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20904 3148 Gracefield Road #518 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 K Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Sarah Schrier Rubin Kest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3148 Gracefield Rd. #518 Silver Spring, MD 20904 Rosenbaum / Husband Arnold 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 12/20/2012 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Licensee MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Severe Dementia years disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the s 1 L Yes 2 L g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? cate has page 2 s perform 1 Yes 2 No certificate 1 Yes 2X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🌠 No Be 26. Place of Death (Check only one) funeral director. Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: After ' 1 X Natural 5 Pending injury 1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 17, 2012 D38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta 9043 Shady Grove Ct. Gaithersburg, MD 20877 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012

DHMH 17 Rev 7/2009

Registrar

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		Registrar 1. Decedent's Nam	- (Final Baids	Ila Look)	Ce	пітісате	of Deat	n	I 2 Poto	Reg. No	D. 2018	3. Time of Death
Physicia Medical Examin			ALYN		CHABDS	N				Day mber 18	Year 2012	0854 hrs
		WENDALYN RICHARDSON 4a. Facility Name (if not institution, give street and number) Holy Cross Hospital						Town, or Location		ľ	4c. County of Death	1
Funeral									er 24Hrs. 8. Date		M/DD/YYYY) 9. Bir	thplace (State or
Director		219-86-9	137	1 M 2 XF	36		Yrs. Month		Min	2-15-1	Foreig	
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 'item 27 is marked other than "natural", or items 23a or 28a-f show any r traumatic event, the Medical Examiner must be notified at once.	ŀ	Usual Residence of 10a. State	of Decedent 10b. County		10c. City	, Town or L	ocation					10d. Inside City Limits
		MD	· ·	GOMERY	S	LVER	SPRING	1X Yes 2 No				
	Director	10e. Street and Nu	ımber				10f, Zip			10g. C	itizen of What Cou	ntry?
the M		1530	HEATH	ER HOLLOW	CIRCLE			20904		- 1	USA	
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5-00; iled with Hygiene I other ti	Completed	17. Father's Name	(First, Middle	, Last)					's Name (First, M	iddle, Maide	n Surname)	
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MD 2121 d 2 should be f Ith and Mental n 27 is marked	잍	19a. Informant's N		ship (Type, Print) AR RICHARD	COM /MOT						City or Town, State	
Baltimore, MI permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traums	ŀ	20a. Method of Dis		AK KICHAKD			sposition (Na	me of cemetery,	WN KOAD, Date	ENF1	ELD, NC 2 Location - City or	.7823 Town, State
Pages 1 nent of H ant: If i		1 XX Burial 2	Cremation	n 3 Removal fro			or other place SAPONI		12-22	12. W	ARRENTOWN	NC
Baltimore, permit. Pages 1 an Department of Hea Important: If iter	-	Donation 5	Other Superal Service					Address of Facilit				
Balti Permit. Departm Importa		Jan		I. Wort	M		1701	LAURENS			. MD 212	IS F.H., INC
Physician		23a. Part I. Enter t failure. List or		complications that ca	used the death	. Do not en	iter the mode	of dying, such as o	ardiac or respirat	ory arrest, s	hock, or heart	Approximate Interval Between Onset and
Medical xaminer	1	Immediate Cause	(Final disease	Urranta	nsive A	thero	sclero	tic Card	iovacsul	ar Di	sease	Death
		or condition result	ing in death)	Due to (or as a	consequence o	of):						
	<u>ē</u>	Sequentially list co		Due to (or es a	consequence o	of):						
	Examine	cause. Enter underlying cause (Disease or injury that initiated overlate resulting in death). Last Due to (or as a consequence of):										
	dical	X UNPENDED)	AMENDED2	3a,27,p	er me	,g936	2-20-13	sm			
Box 68760, e death certificate be ext the attending physician ed for use as the bunal -		IF FEMALE: 23b. Was decedent	pregnant in t	ho	utcome of preg		1 =	2 DEstant		2	3d. Date of delivery	
ox 687 eath certific	cian	past 12 months? 2 Petal death 5 Other (Specify)							c pregnancy	- 1	Mońth [Day Year
BOy e death the att	hysi	1 Yes 2	No 9 🗸 Un	known 9 Unkno	wn		, 0,10, (-,-					
P.O.	含	Part II. Other sign	ificant condi	tions contributing to	death but not r	esulting in	the underlying	g cause given in Pa	art I. 23e			the cause of death? pably 4 Unknown
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cor e law r e has b	힡								—	autopsy performed	death?	completion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case refe	rred to medica	1				26.Place of Death		Yes 2	No 1 ✓ Ye	es 2 No
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ision Attendi r death. rector: /	atio	1 X Natural 2 Accident	5 Pen	ding stigation				1 Yes 2	No			
Division of Vital Records, sopital or Attending Physician: The law require hours after death. Inneral Director: After this certificate has been siy filled in by the funeral director, page 2 should by	Certification:	3 Suicide		ld not be	of Injury - At h	ome, farm,	street, factory	, office building, et		ation (Street own, State)	and Number or Ru	ral Route Number, City
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To the Ho within 24 Professional To the Furcompletely	Medical	(Check only one) 2		hysician: To the best nminer:On the basis o	f examination a							
To the within. To the comple	Mec	and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo									nth, Day, Year)	
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Sta Registr		31 Date filed (Mor	oth, Day, Year) 9_1_20 1		gistrar's Signati	bare						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 19. James Lee Robinson 2012 Medical 7:50 am 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Months Hours (Month, Day, Year) Director 437-26-3846 1 X M 2 □ F 85 Yrs 08/02/1927 Louisiana trie marked other than "natural", or items 23a or 28a-f ehow treumatic event, the Medical Examiner must be notified at 10a, State with the Maryland 10b. County Director 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 12804 Broadmore Road 20904 u.s.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 A Yes 2 No 1950—
If Yes, Give
Year or Dates. 1951 Black, White, etc. ۵ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72 h and Mentai Hyglene.
7 le marked other than "r Government Elementary/Secondary (0-12) College (1-4 or 5+) Director of Head Start Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Matthew Robinson Eva Love 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Juanita M. Robinson - Spouse 12804 Broadmore Rd., Silver Spring, Maryland 20904 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If Ite any Injury or ot 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Parklawn Mem. Park 12/27/2012 4 Donation 5 Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Parkinson's Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dementia Examine Due to (or as a consequence of). physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day sate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 4 Ki Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOUSOC 8h v mus December 19, 2012 D0047330 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Thomas Joseph,

MD,

50 W. Edmonston Drive., Suite 207, Rockville, Maryland 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HATTIE, M. REDD 23.28 M 2012 Medical 16 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death MD GOOD SANARITAN BALTIMORE HOSPITAL N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 11/2/1923 **Funeral** Birthplace (State or Foreign Country) Director 214-24-3727 Usual Residence of Decedent 1 🗌 M 2 🕱 F S.C. 27 is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours efter death with the Maryland fleatith and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1315 E. Lafayette St. 21213 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No
If Yes, Give 0. Black, White, etc. <u>م</u> 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify: Specify: Black Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Minister Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Wes Walker Lizzie M. Richer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia Williams-Daughter 1630 Sherwood Ave. Baltimore, Maryland 21239 permit. Page 1 and 2 Depertment of Health Important: If item 27 any Injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Mem. Park 12/21/12 Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East 1101 E. North Ave. Baltimore, MD 21202 Syne the 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULMONARY EDEMA disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner ACUTE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consumence of To the Hospitar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC RENAL FAILURE, HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES MELLITUS autopsy performed? 1 Yes 2 No Yes 2 N r After this certificate funeral director, r 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge of attributions of the time date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/16/2012 RES 000 M.D. V. Manasa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VULCHI, MANASA

State

Registrar

31. Date filed (Month, Day, Year) **DEC 2 1 2012**

Box 68760

P.O. I

Division of Vital Records.

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2. Registrar's Signature

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Physician/ 1³9 2012 11:59 a M December Jacquelyn C. Rich Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Ellicott City 8720 Ridge Road Apt. 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) **Funeral** Director 213-26-3319 1 🗆 M 2 🔀 F 83 MD 12/06/1929 Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2 No Ellicott City Howard MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21043 8720 Fidge Road Apt. 112 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. <u>Ş</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: White Completed 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clyde's Restaurant Cook Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental h မ ReEtta Elina Buppert of Health and Menta fitem 27 is marked r other traumatic e Ralph Elliott Amoss, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Falling Waters, WV Wynona M. Davis - sister 768 Broad Lane Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/22/2012 Marriottsville, MD 4 Donation 5 Other (Specify) View Cenetery 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. . Sign two of Funeral Service License 21043 Manita 4112 Old Columbia Pike Ellicott City, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 100 disease or condition Medical resulting in death) Examiner sean Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed the burial-trar and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician by Physician/Medical Box 68760 for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Month Year Day Pregnant at time of death detached 9 Unknown g Unknown P.O. þ 23e. Did tobacco e contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed be should be det 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2 1 Tes 2 🗌 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\ext{Hesidence} \) 6 \(\text{Other} \) Other (Specify) 1 Tyes 2 🕳 1 Inpatient 2 ER/Outpatient 3 DOA ည this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner o 28b. Time of 28d. Describe how injury occurred Certificate: injury Hatural 5 Pending hours after death Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, rte. .in 24 houre. .se **Funeral Dire.** .v filled in bv þ 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number cause of death (Item 23a) (Type, Print) NY 31. Date filed (Month, Day, 2. Registrar's Sig State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ 8:40 AM 201 mer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death G Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) -4714 193-20 Director 1 M 2 X F in then "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits flled within 72 hours after deeth with the Maryland Director 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pege 1 and 2 should be filed within 7. Department of Health end Mentel Hygiene. Importent: If item 27 is marked other then 'eny Injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) mes 19a. Informant's Name/Relationship (Type, Print) God 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 21. Signature of Funeral Service License llam Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ettending physicien end for use as the burlal-transit or Attending Physicien: The lew requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) been signed by the eshould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗆 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖾 Residence 6 🗌 Other (Specify) 1 Yes 2 No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funerel Direct completely filled in by à Medical 29a. Certifier 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 20 pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14000 45 2012 Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Parkville 2325 Ellen Avenue 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Maryland 1 🗙 M 2 🗆 F 04/09/1930 Director 82 218-26-2460 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 No Parkville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21234 U.S.A. 2325 Ellen Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces?
XYes 2 No Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 1950-53 Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Scales Scale Mechanic 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Α. Gott Rawlings Rose Milburn D. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21234 2325 Ellen Avenue, Parkville, Dolores T. Rawlings / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 12/20/2012 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 22. Name and Address of Facility of Funeral Service Ste. P, Hanover, MD 21076 7522 Connelley Dr., Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Wetas Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to for as a consequence of, or Attending Physician: The law requires that the death certificate be executed tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No I ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 12 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl 6 Could not be Suicide within 24 hours after de:

To the Funeral Director

completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) title of certifie 29b. Signature a nd address of person who completed cause of death (Item 23a) (Type, Print) T. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 20, 2012 Physician/ Dennis Reinhardt 5:45 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Towson B<u>altimore</u> 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months August 5,1957 Mary Land 212-78-2470 55 1 XM 2 □ F Director Yrs. permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or items 5% ~ ~ ~ 0000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Baltimore 1 ☐ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9666 Dixon Ave. 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 X Never Married 2 Married ģ 1 ☐ Yes 2 No Specify: White Completed Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance Worker Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph L. Reinhardt т. Mirabile Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Perkins / Sister 1900 Treeline Drive Forest Hill, Md. 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State Holy Redeemer Cem. 4 ☐ Donation 5 ☐ Other (Specify) 12/27/2012 Baltimore, Md. 21. Signature of Funeral Service Lice 22. Name and Address of Facility 1050 York Road Inc. Towson, Md. 21204 Ruck Towson Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Stroke Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physician: The lew requires that the death certificate be executed Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day ☐ Yes 2☐ No To the Hospital or Attending Physician: The lew requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompletely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 N 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifi 29d. Date signed (Month. Day, Year) December 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) **DEC 2 1 2012**

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:47 Ам David Crandall Sarvis, Medical Dec 20 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1431 Galena Road Baltimore If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Min Hours 251 26 5784 Usual Residence of Dec **Director** 1 ★ M 2 □ F 88 1924 South Carolina Dec. 18, 28a-f shov ä 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Directo must be notified Baltimore 1 Yes 2 X No Md. Essex the 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1431 Galena Road 21221 USA death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten Examiner ı 11. Marital Status 14. Race - American Indian. Black, White, etc ğ 1 Never Married 2 Married 1 Yes 2 No 1941 If Yes, Give filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ₩ Widowed 4 □ Divorced Specify "natural" Completed WW II White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Mechanic Manufacturing 12 event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 other traumatic Oscar Sarvis Addie Mae Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a David Sarvis, Jr. Son 1429 Galena Road Essex, Maryalnd 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If i any injury or conce. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Gardens Of Faith Cem. 12/22/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. Sur Mire Funerti S 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave Essex, Maryland 21221 Part 1. Enter the disease, or of shock, or heart failure. List only that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between
Onset and Death each line Immediate Cause (Final Phulici n Pm disease or condition Medical resulting in death) Jue to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Et to orderlying Cause (Disease or injury that initiated events -tran Due to (or as a consequence of): resulting in death) Last ding physician Physician/Medical certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death g ☐ Unknown be detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 🔀 No 2 🗌 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be Accident pletely filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 3 8 December 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYII Old Frederick Rd Suik LP Sharon Me Cormack Md- 21229 Old Rd Baltimore,

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sentz Month 10:11 AM avmono 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balt more N/A 1410 Dita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 ₹ M 2 □ F Director 213-40-1347 9/14/1941 MARYLAND 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No N/A MD BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ROLAND AVENUE 21211 USA 3437 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Ø Widowed 4 ☐ Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE LABORER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be file I Health and Mental H item 27 is marked o ٥ CLIFTON SENTZ RUTH BURKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) COURTNEY R. SENTZ/DAUGHTER 3435 ROLAND AVENUE BALTIMORE, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY, INC. 12/29/2012 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intra-abdomina bleeding disease or condition TEMPERATION MARRIENTO BY WORKS ELWINER Medical resulting in death) Due to lor as a consequence of Examiner Spenic laceration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami use as the burial-transit Cause (Disease or injury tall that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 5 Other (specify) Month Pregnant at time of death signed by the at Id be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2 No 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 X Accident
3 Suicide
4 Homicide 500AM 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Jown, State)
3457 Relead Az Apt | ZIZI Balteren JOME Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie RES-600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Baltmar. Orleans DEC 2 1 201 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per fh 2934 12-27-12
State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Tanya Dawn Stafford DECEMPORE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE AGNES HOSA/TAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 219-52-3183 **Director** 1 □ M 2 🗓 F 64 Oct 14,1948 Virginia Usual Residence of Decedent or 28a-f show Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d Inside City Limits 10a. State Director 1 🗆 Yes 2 🛣 No MD **Baltimore** Halethorpe 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 2419 Zion Road 21227 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. ρ 1 X Never Married 2 Married 1 Yes 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Recreation Director Local Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည th McKee1 Cleaon Stafford W. 19a. Informant's Name/Relationship*(Type, Print)* Joyce Guthrie — Sister 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 584 A Street, Pasadena, Mary Land 21122 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) 12/15/12 Glen Burnie, MD ^{22. Name} and Address of Facility $ext{Gary L. Kaufman Funeral Home at MMP, Inc.}$ 21. Signature of Funeral Service I 1283 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Elkridge, MD 21075 23a. Part 1. Enter the disease or on shock, or heart failure. List only Approximate Interval Between one cause on each line Onset and Death ANKNMANI A Immediate Cause (Final Ph, si∟ian/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) nding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregrent in the past 12 months?
1 ☐ Yes 2 ☑ No 23d Date of delivery 3 Ectopic pregnancy signed by the atten d be detached for u Month 5 Other (specify) Pregnant at time of death Unknown STAFFORD , LAW YA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ NSTEMI 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death?

1 Yes 2 No To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy performe Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ninpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mN DECEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEFN FAUL RYPSALES 900 S CA 900 21229 BALTIMORIE MD CATAN AVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Grace Taylor Schutt 945 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City Baltimore City** Union Memorial Hospital If Under 24 Hrs. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country 217-26-0368 84 **Director** 1 🗆 M 2 👿 F Mar 3, 1928 Yrs 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location must be notified at Director MD Anne Arundel Hanover 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6132 Hanover Rd. items 23a 21076 U.S.A. death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Force Black, White, etc. ō þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Specify Completed 3 Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home unlineusa other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ernest G. Taylor Blanche Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean DeBoy daughter 6399 Lawyers Hill Rd. Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Dec 20, 2012 Glen Burnie, MD Atlantic Crematory, LLC 4 Donation 5 Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Yeur Medical Due to (or as a Examiner Saquertially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pre 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death detached signed by the Unknown the underlying cause given in Part I. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? 2 pe (Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes plnous Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has this certificate 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. funeral director, 25. Was case referred to 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ER/Outpatient 3 DOA 27. Mann Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural work 5 Pending Yes 2 🗆 No filled in by the Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 06-2011

State

(Check

31. Date filed (Month, Day, Year)

29b. Signature

of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 5 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **Edward Allan Stoesser** Month Dec 17, 2012 Year 0 7:58 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard 11418 Barrow Downs Columbia 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Min Mar 31, 1956 NJ 790 146-42-9489 Director 1 X M 2 - F 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland 1 notified at Director Columbia MD Howard 1 Yes 2 X No 10e Street and Number 9 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 21044 U.S.A. 11418 Barrow Downs 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Examiner Black, White, etc. ō ρ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. EUNARD life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Customer Service** Retail Grocery 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked o 2 Gloria Naclerio Edward Jospeh Stoesser traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce, 11418 Barrow Downs Columbia, MD 21044 Gloria Herrick Mother 55ER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Columbia Memorial Park Dec 19, 2012 Clarksville, MD Donation 5 Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service Lice Hunkellen P art 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between PARKINSONS mediate Cause (Final set and Death Physician/ mas disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami rents 1 transosmesi 4 and Due to (or as a consequence of) ding physician Physician/Medical certificate be Box 68760 the ! use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops page 2 2 🗆 No 1 Yes Division of Vital 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes ပ 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Year injury 5 Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) D31172 Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 CHANTEN DRIVE 200 0 32. Registar's Sign

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December 19, 2012 Richard Anthony Soi leau 8:18 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Birthplace (State or Foreign Country) **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours (Month, Day, Year) Director 436-84-9822 1 🛛 M 2 🗆 F 62 02/10/1950 Georgia 28a-f show ed other then "natural", or items 23a or 28a-f sho event, the Wedical Exeminer must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 250 Chantrey Road 21093 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 3 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72 h and Mental Hygiene, 7 is marked other then " Elementary/Secondary (0-12) College (1-4 or 5+) Sales Manager Heavy Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clany Soileau Vernese Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Deidre Soileau / Wife 250 Chantrey Road, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 12/20/2012 Hanover, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death a Complications of Physician/ whole brain , madiation disease or condition resulting in death) Medical Due to (or as a consequence of): [∡]Examiner markel CCVI CarcinonA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ettending physician and for use as the burial-transit Exam or Attending Physician: The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the e P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been sig 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy tor: After this certificate the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital 8 26. Place of Death (Check only one) 2 No Other: 4 🗆 Nursing Home 5 🗆 Residence 6 🗁 Other (Specify) 1 Yes ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 \square Pending To the Hospital or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier A Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 18303 December 20 2012

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLIES

M) 6701 N.

Charles

MOSWOT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 204 Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 802 Dale Road Anne Arundel Glen Burnie Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral (Month, Day, Year) Director 218-42-2061 1 M 2 D F 68 07/10/1944 Maryland 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heelih and Mental Hygiene. and: If item 275 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, It is Marical Expression must be notified at ury or other traumatic event, It is Marical Expression. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 802 Dale Road 21060 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Schmidt Hazel Rebecca Mauler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Giovanna Caponiti / Wife 802 Dale Road, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite eny Injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 12/20/2012 | Hanover, Maryland 21. Signature of Funeral Service L 22. Name and Address of Facility Anatomy Gifts Registry MD 21076 7522 Connelley Dr., Ste. P, Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) leve h Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Undarying Cause (Disease or injury Due to (or as a consequence of): Exami attending physician end for use as the buriel-transit I or Attending Physician: The law requires that the death certificate be executed Direct cleath.

Director: After this certificate has been signed by the attending physician enter in by the Innoral director, page 2 should be detached for use as the buriel-transit in by the Innoral director, page 2 should be detached for use as the buriel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 1 ☐ Yes 2 🗗 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 € No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident М Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after
To the Funeral Directory Hospital of 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier impleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 | 4 | 589 State of Maryland / Department of Health and Mental Hygiene

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ledical Exami		Kristin Lin Smith		Month December		1319 hrs						
			n, or Location of Deat	th	4c. County of Death							
. 1		Frederick Memorial Hospital Frederick Frederick										
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months	Year If Under 24Hr Days Hours Mir		(MM/DD/YYYY) 9. Birth Foreign	1						
Director		214-80-2910 1 M 2XF 38 Yrs.	54,0	06/12/	/1974 Col	^{ntry)} Maryland						
>-		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10d Inside City Limits						
w any						1 Yes 2 X No						
Aaryland 28a-f show 1 at once.	ğ	MD Frederick Monrovia		140	g. Citizen of What Coun							
Mary r 28a	Director	10e. Street and Number 10f. Zip Co	жае	10,	g. Citizen of What Coun	u y ?						
and 2 should be filed within 72 hours after death with the Maryland tealth and Montal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		4936 Greenvalley Road 217			U.S.A.	I. Prop Direct						
th wi	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify C	of Hispanic Origin? (S Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,						
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rs after ural",	<u>a</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occ		work done	Specify: Whit							
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36 hin 7 e. etica	흵	12 Homemaker			Own Hom	۵						
d wit	5	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, M								
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	B B	Edward Skarda, Jr.	Judith	Bre	eseman							
21 ould ould d Mer		19a. Informant's Name/Relationship (Type, Print)	Street and Number or	Rural Route Numb	oer, City or Town, State,	Zip Code)						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natingury or other traumatic event, the Medical Examples.		Edward Skarda, Jr. / Father 2502 Catoct	in Court,	Apt. 1D	, Frederick	MD 21702						
re, lan fitter friter er tru	- 1	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of crematory or other place)	of cemetery,	Date	20c. Location - City or	rown, State						
Baltimore, permit. Pages I as Department of Hec Important: If ite		4 X Donation 5 Other Specify: Anatomy Gifts Reg:	istry 12	/20/2012	Hanover, M	aryland						
alti mit. partm ports	1	21. Sign ture of Funeral Service Lice 22. Name and Ad	dress of Facility	Anaton	ny Gifts Re	gistry						
w squii		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of death.	nelley Dr	., Ste. I	P, Hanover,	MD 21076						
Physician		failure. List only one cause on each line.			st, shock, or heart	Between Unset and						
Medical		Immediate Cause (Final disease a. Complications of Methadone	Intoxicat	ion		Death						
		or condition resulting in death) Due to (or as a consequence of):										
	اء	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
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ecute and	<u>e</u>	d. AMENDED AMENDED 23a, 27, 28a-f, per me, §	g035 1_0_1	3 cm								
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and implicitly filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contract of the funeral director, page 2 should be detached for use as the burial - transition of the contract of the funeral director, page 2 should be detached for use as the burial - transition of the contract of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director.	Medical		g933 1-9-1	. Ј БШ								
376 ficate g phy s the b		IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death	3 Ectopic pregn	nancv	23d. Date of delivery Month D	ay Year						
K 68	Si.	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		,								
Box 687 e death certifice the attending p ed for use as th	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown										
ords, P.O. v requires that the s been signed by t		Part II. Other significant conditions contributing to death but not resulting in the underlying car	use given in Part I.		pacco use contribute to t							
ires the signe	d by											
ords, w requir is been s	ete			24a. Was a autops	y prior to o	opsy findings available ompletion of cause of						
Reco The law icate has	Completed			perform 1 Yes 2		s 2 No						
Division of Vital Records, P.O. falor Attending Physician: The law requires that the stater death. at Director: After this certificate has been signed by the funeral director, page 2 should be detabled in by the funeral director, page 2 should be detabled.	0		Place of Death (Check	k only one)								
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ding Ph	盲	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c (Month, Day, Year)	. Injury at Work?	1	ow injury occurred							
tendii eath.	읉	Natural 5 Pending Fd 12-14-12 Fd 01:00 am 1 Pending Investigation	Yes 2 X No	accident	tal overdos	е						
ViSi or Att fler de in by	22	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, of	fice building, etc.	28f. Location (St	treet and Number or Runate) 5927 Dorse	al Route Number, City						
Divisipital or At ours after d	Certification:	4 Homicide determined (Specify) Multi-Family Apt.		Frederic		,						
Hos 24 hc Fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only)										
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my op and manner stated.	<u> </u>	at the time, date a								
	Σ	21	icense number		29d. Date signed (Month, Day, Year)							
		Pankly Withell MA	D.C.M.E.		December 19, 20	12						
		30. Name and address of person who completed cause of death (Item 23a)		timene NAD 04	222							
			more Street, Bal	timore, MD 21	223							
St Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature										
		DEC 2 1 2012 Ann B. Market			OCME							
DHMH 17 Rev 1/2	UU1	ORIGINAL										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 12:510M Taylor Gloria 12 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Baltimore, MD Samaritan Hospital If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 8. Date of Birth **Funeral** Days (Month, Day, Year) 294-62-8327 Director 1 M 2 XF 56 Yrs Ohio 08/10/1956 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at 10b County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director Baltimore N/A 1 XYes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21219 38th Street 716 E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 2 Yrs. Elementary/Secondary (0-12) Johns Hopkins Hosp Histology Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lela Lydle Leonard Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 E. 38th St. Baltimore, MD 21219 Kenneth B. Taylor (Husb.) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site Crematory 12/21/12 Baltimore, MD 22 NosephpreMof Farmrown, Jr. Funeral Home PA 21. Signature of Funeral Service License 2140 N. Fulton Ave. Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multi organ Due to (or as a consequence of): disease or condition Medical resulting in death) Éxaminer Shoc Septic Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal Disease, Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia, Tachyarrhythmia After this certificate has autopsy 1 Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 5 🗌 Pending 1 Natural Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) es 000 MD 18/19/12 Im 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Balhmore, MD

Eliason

2012

32. Registrar's Signatur

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 17, lurner Physician/ 11:41 AM rose la Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homore John< HOPKins HOSPITA 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Numbe If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/30/1964 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🖔 F Director 230-11-1795 48 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1X Yes 2 ☐ No Frederick Frederick MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 USA 1421 Taney Avenue 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Narried Completed by Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia James Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9720 Damascus Drive, Manassas, VA 20109 George W. Turner / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/21/2012 Beltsville, MD Chesapeake Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No 24 hours after death.

Funeral Director: After this certifical letely filled in by the funeral director. Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA |으 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie e number

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

December 17, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DEC 2 1 2012

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph F. Toland Month 8:40 A. M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dacota House Assisted Living Harford Aberdeen If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 168-20-3677 84 Director 1 M 2 D F 12/16/1927 Pennsylvania 1 end 2 should ba fliad within 72 hours aftar daath with the Maryland of Health and Martlei Hygiana.
If the Az 7 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Medical Examinations in the motified and the contract man be notified as 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 1406 Muirfield Close 21015 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 → Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Service Manager Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Toland Leticia McKenna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Muirfield Close, Bel Air, Maryland 21015 Kathleen Jarczynski 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Paga 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Paga Depertmant o Important: If any injury or 12/20/2012 4 Donation 5 Other (Specify) Resurrection Cemetery: Bensalem Twp., PA Marzullo Funeral Chapel, P.A. Marzullo Funeral Chapel, P.A. Marvland 21214 21. Signature of Funeral Service Licenses 22. Name and Address of Facility nichael 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) WOING Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attanding physician and I for usa es tha burlal-transit Exam or Attending Physician: Tha law raquiras that the daeth cartificate ba exacutad Cause (Distance of injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year signed by tha a d ba datachad f 1 Yes 2 Unknown 9 Unknown P.0. Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlyi*n*g cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed this cartificate has baen siral diractor, paga 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yes 2 ☐ 100 2 No To the Hospital or Attending Physician: within 24 hours eftar daath.
To the Funeral Director: Aftar this cartiflo complataly filled in by tha funaral diractor, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Sp 1 Tyes 2 4No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar

State

Name and address of person.

Ionth, Day, Year)

DEC 2 1 2012

Mho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 04041 AM Medical Doris L. Vincent 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BAUTIMORE AGNES HOSPITAL If Under 1 Year If Under 24 Hrs.

Honths Davs Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign UNK Director 1 □ M 2**X** F 87 Sept. 27, 1925 West Virginia Usual Residence 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner is ust be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Halethorpe 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4769 Drayton Green 21227 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married δ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Mental Injury or other traumatic event, the Ment Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Braun Mary F. Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecilia A. Vincent-Kotalik -144 Cherrydell Road Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Trinity Cemetery Dundalk, MD 12/18/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final HYPERCARBIC RESPIRATORY Onset and Death Physician HYPOXIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner LUNG COLLAPSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Certificate: To Be Completed by Physician/Medical VINCENT DRIS Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day 1 Yes 2 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAU FAILURE 1 Yes 2 No 3 Probably 4 V Unknown COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate I Yes 2 N 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: After this certifice etely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Vithin 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD union Carr P25481 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTMORE, MD 21229 CALATA AVE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Martin N. Wheatley December 2012 7:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1014 Collwood Road Baltimore <u>Catonsville</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 1 **X**M 2 □ F 215-05-0979 92 5/5/20 Maryland at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director rral", or items 23a or 28a-f s Examiner must be notified MD 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1014 Collwood Road 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 🏖 Widowed 4 □ Divorced Specify: White Year or Dates and Mental Hygiene.
Is marked other than "natur aumatic event, the Medical | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Anaylist Supervisor Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Wheatley George unknown traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Department of Health Important: If item 27 any injury or other to once. Louis J. Weinkam Sr. / Attorney 1002 Frederick Rd. Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 12/22/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Loudon Park Funeral Home Ce 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or co shock, or heart failure. List on nplications that caused the death. Do not enter the one cause on each li*n*e Approximate Interval Between Onset and Death Immediate Cause (Final Phairian disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Pregnant at time of death Day Year the be detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2 s performed 1 ☐ Yes 2 ☐ No Yes 2 the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 . 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner ath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of dertific 29d. Date signed Month, Day Year) 30 Nar State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 18, 2012 01ga 11:15 M Marie Woerner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months (Month, Day, Year) Days 219-30-0908 Director 1 M 2 X X 79 05-20-1933 MD Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaritiner must be notified at ORDE. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Directo MD Harford Forest Hill 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2011 Tiffany Terrace 21050 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed 3 Widowed 4 Divorced Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Consultant Nursery Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ John Nieper Baltzell Dorothea M. Lehmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. Woerner - husband 2011 Tiffany Terrace, Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Pk. 12-21-2012 Elkridge, Maryland 21. Signature Funeral Service Licer 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician/ disease or condition MELANOMA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and I for use as the bunal-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [Ω Completed 1 🗌 Yes 3 Probably 4 Unknown No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy this certificate Yes 2 K the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certifical mpletely filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2.

To the F only one 29b. Signature and title of o 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar TRACIE L.

31. Date filed (Month, Day, Year)

MORGAN,

CRNP

32. Registrar's Signature

DECEMBER

OLGA WOERNER

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Decembe Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death County of Death **Examiner** Crescent Cente Kiverdale nnce 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, 1 🗆 M 2 🗓 F Months Hours Min North Carolina **Director** 234-64-6004 Jan. Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a 1 X Yes 2 No DC Washington 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be r Funeral 20018 1417 Saratoga Avenue NE USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Private Homes other i Domestic permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Thomas Dewitt Annie Mae Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McKinly Williams 5405 19th Avenue, Hyattsville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Devotional Gardens 12-15-12 4 Donation 5 Other (Specify) Signature of F neral Service Licen e ^{22.} Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying
Cause (Disease or linjury Due to (or as a consequence or). the attending physician and hed for use as the burial-transit Hospital or Attending Physician. The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O, Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 0ther (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work's Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death.

To the Funeral Director; After this certificate has been

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marshalee 31. Date filed (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30, per DVR, g934 12-21-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2117 Delores E WATKINS ecember 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital Samaritan manyland Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Pate of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) Director 215-32-9073 1 □ M 2 🕱 F 76 Yrs 3/27/1936 MD in than "natural", or items 23a or 28a-f show the Medical Examiner nigst be notified at 10a. State 10b, County 10c. City, Town or Location filed within 72 hours efter death with the Maryland 10d. Inside City Limits Director Baltimore MD N/A 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 USA 2565 Cecil Ave Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) N/A 10th N/A Unemployed 1 end 2 should be filed wit of Health and Mentel Hygle Item 27 is marked other: other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Samuel Milburn Watkins, Sr. Rita E. Connor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Roye-Daughter item 2 other Cecil Ave. Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 of Popartment of Pinportant: If its any injury or of once. 1 D Burial 2 X Cremation 3 D Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 12/24/2012 Baltimore, MD 21. Signature of Funeral Service Licenses March F/H-East 22. Name and Address of Facility North Ave. Baltimore, MD 21202 Imite 1101 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician arrhythmia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) To the Hospital or Attending Provincian: The last completely the ettending physician and To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 17/1 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Gettigring rigistical in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rowell MD D73618 December 18, 2012 who completed cause of death (Item 23a) (Type, Print) MD 5601 Loch Raven Blvd. Baltimore, MD, 21239 31. Date filed (Month, Day, Year) 2012 32. Registrar' Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18 Day 2012 Year Physician/ М Alice Munah Wreh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace Birthplace (State or Foreign Country)
 Chana Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🕮 Hours 5/937/1939° 73 Ghana Director 213-59-5024 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Ves 2 X No Harford Havre de Grace Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 21001 313 Goforth Drive Ghana 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Afro-American "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event the (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) kind of work done during most of working Elementary/Seconday (0-12) College (1-4 or 5+) in home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Blamo James N. Wreh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Goforth Dr., Havre de Grace, MD 21078 Saye Ben Tukpei (son-in-law) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gardens 12/29/12 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Leensee Aberdeen, Maryland 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final SEASE Ph. sician/ disease or condition Medical resulting in death) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to dical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No ပ္ 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Year 2012 A^{M} 1:15 Chaoung You Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Home Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) 03/10/1926 Country) South Korea 1 □ M 2 🖔 F Director 576-69-2645 86 Usual Residence of Deced r than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 10a State 10b. Count filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Howard Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6334 Cedar Lane 21045 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Year or Dates Asian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Did Not Work N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be file rtment of Health and Mental H rtant: If item 27 is marked of njury or other traumatic ever 2 See Kyun You 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juhyun Chung / Daughter 4203 Sleepy Lake Drive, Fairfax, VA 22033 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beltsville, MD Chesapeake Crematory 12/16/2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mayshall Dorota Marshadl Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ VER disease or condition ANCER Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or mjuly that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed page 2 should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy ☐ Yes 2√ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Tyes 212/No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury safter death. work? 1 ☐ Yes 2 ☐ No Accident
Suicide the 1 Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. determined within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number reple MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite MO 9650 Jenhay Shakunmale ofe 21045 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 6:20 pm 2012 Charin Yuthasastrkosol Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 9715 Leatherfern Terrace, Montgomery Village Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 169-46-3326 1 □ M 2 🗓 F 81 12/30/1930 Thailand Usual Residence of Decedent Hygiene. other than "neture!", or items 23a or 28a-f show ent, the Medical Examiner must be notified et 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland 1 Yes 2 X No Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9715 Leatherfern Terrace, 20886 u.s.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian Completed 3 X Widowed 4 Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Vice President Sales Be permit. Page 1 and 2 should ba fliad Dapartment of Haalth end Mantal Hy Importent: If item 27 is marked oth eny injury or other treumetic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Luang Prasert Vithirat Jaruck Boontham 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita P. Yuthasastrkosol/ 9715 Leatherfern Ter., #C. Montgomery Village. MD 20886 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 X Removal from State Everly Crematory 01/06/2013 | Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Everly-Wheatley Funeral Home 21. Signature of Funeral Service Licensee 1500 West Braddock Road, Alexandria, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Non-Small Cell Lung Carcinoma disease or condition resulting in death) Medical Due to for as a consequence of: Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of) attending physiclen and for use as the burial-transit Cause (Disease or injury or Attending Physicien: The law requires that the death cartificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
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9 ☐ Unknown Pregnant at time of death 5 Other (specify) Day ed by the a detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð should ba c Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy performed? 1 ☐ Yes 2 🗓 No death? certificata 1 Yes 2 🗌 No Division of Vital funaral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin{picture}(\begin(\begin{picture}(\begin(\begin{picture}(\begin(\begin)\begin{picture}(\begin(\begin{picture}(\begin(\begin{picture}(\begin(\begin(\begin(\begin{picture}(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(\begin(2 🕅 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending To the Hospital or Attendin within 24 hours aftar daath. To the Funerel Director: Aft complately fillad in by tha fur 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my spirits and each accurred at the time date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) MD039137 December 13. 2012

Registrar

State

3800 Resevoir Road, NW, Washington, DC 20007

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

M.D.

George K. Philips,

31. Date filed (Month, Day, Year)

12-09531

Travis Young		State of Maryland / Depar	lelible ink. Ensure All Copies Are I tment of Health and Mental Hygiene										
Physic	rian	Registrar Certi	ficate of Death	2012 4160 Reg. No.									
Medical Exar	nine	Travis M. Young	2. Date of Month										
)		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Death	4c. County of Death									
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mornell Hygien. Department: If item 27 is marked other than "natural", ar items 23a nr 28a-1 and injury or inter traumatic event, the Medical Examiner must be notified at once	ဥ	19a. Informant's Name/Relationship (Type, Print) Pamela Murphy	9b. Mailing Address (Street and Number of Rural Route M										
TOFE, MD 2 ages 1 and 2 shou nt of Health and N :: If item 27 is on other traumatic		20a. Method of Disposition	120 Brythedate Road Perryvi	lle, Maryland 21903									
Baltimore, Dermit. Pages I ar Department of Hee Important: If ite		Removal from State Cremation 3 Removal from State Cremation	POT OTPTher place)	20c. Location - City or Town, State 2 Hanover, Maryland									
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y de si	2 ا د	Plan. Certifier 1 Certifying Physician: To the best of my knowledge dea	or Town, S										
To the within To the comple	ᄝᆫ	2 Medical Examiner: On the basis of examination and/or in and manner stated 9b. Signature and title of certifier	en occurred at the time, date and place, and due to the caus expecting to the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and place, and due to the caus expecting at the time, date and the control of the caus expecting at the time, date and the caus expecting at the time, date and the caus expecting at the time, date and the caus expecting at the caus expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting expecting exp	e(s) and manner as stated and place, and due to the cause(s)									
	2	29c. License number 29d. Date signed (Mor											
	30	Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	December 18, 2012									
		Ana Rubio M.D., Ph. D. Assistant Medical Examiner	and the state of t	223									
Stat Registra	e 3 Ir	1. Date filed (Month, Day, Year) DEC 2 1 2012 Registrar's Signature	barke										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #2 per phy, g934 12-26-12 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar 41602 Reg. No. Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Physician/ Month ANDERSON CI: OCAM M DMUND Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death remo Social Security Numbe If Under 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Funeral If Under 24 Hrs. (Month Day Year) 35 1 XM 2 - F Months Hours Min 218-30-7424 77 Yrs MD Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tier 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2X No MD Anne Arundel Gambrills 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21054 2604 Chapel Lake Drive Unit 107 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. White 3 🗆 Widowed 4 🗆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Western Electric 12 Inspector Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dorothy Anderson, Sr. Edmund 21054 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2604 Chapel Lake Drive Unit 107 Gambrills, MD Mrs. Jennie Lee Anderson /Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Glen Haven Mem. Park 12/21/2012 Glen Burnie, MD 21. Signature of Funeral Service Ligens MO1479 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD once. Singleton Funeral & Cremation Services, PA the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that cause Approximate Interval Between shock, or heart failure. List only one cause on each in Immediate Cause (Final Onset and Death Physician/ enc Inknown stage chronic dostructive dispos disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any lineding to immedicause. Enter Underlying Due to lor as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Be Completed by CVA-1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

(Check only one) 29b. Signature

(Month, Day, Year)

20

2012

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney 0 | 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 21, 2012 Physician/ Clarkie R. Bohon 1:08 PMM (AKA Robert C. Bohon) Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Health Services ROSSVILLE Rosedale Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** 236 40 9050 1 X M 2 🗆 F Director 05/04/1928 West Virginia 84 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director Maryland | Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral with 21220 United States 33 Hydroplane Drive permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: amy injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces?

1 Xes 2 No 2-54

If Yes, Give 1952-54 Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Styles Howard Bohon Flosy 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth R. Bohon (son) 8359 Tamar Drive Columbia Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Fremation 3 🗀 Removal from State Bayview Crematory INC 12/24/2012 Baltimore Maryland onation 5 Other (Specify) of F Service Licenser 21. Sign tur ^{22. Name and Address of Facility} Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 22. Name and Address of Facility nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. 23a. F Approximate Interval Between Onset and Death Immediate Gause (Final disease of condition resulting in death) Phy i i n Cardiomyopathy Medical Due to (or as a consequence of) **Examiner** HTN Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury Uncontrolled Diabetes that initiated events resulting in death) Last Due to (or as a consequence of): as the burialnding physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be **PVD** Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Ŷ Day Month Year 5 Other (specify) Pregnant at time of death g 🗌 Unknown g Unknown hed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign. 1 Yes 2 No 3 Probably 4 No Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No has this certificate 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 XNo ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 X Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, þ 4 Homicide determined City or Town, State) Medical 1🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0073841 12/22/2012 >/H /) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 Waltham Woods Road Suite 204 Parkville MD 21234 Shushil Sagar . Date filed (Month, Day, Yea 32. Registrar's Signature DEC 2 6 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 9:10a [™] 19 2012 **AMOS** December HEZEKIAH 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death BALTIMORE MANOR CARE NURSING & REHAB TOWSON 8. Date of Birth (Month, Day, OCT • 7 Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Months Days Hours Min. 85 176-24-4549 PENNSYLVANIA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County XXYes 2 □ No N/A BALTIMORE MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21206 5202 PLAINFIELD AVE 12. Was Decedent Ever in U.S. Armed Forces? Y∏Yes 2 ☐ No If Yes, Give Year or Dates: 50/52 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc tXXNever Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CORRECTIONAL OFFICER LAW ENFORCEMENT 12 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5202 Plainfield Ave., Baltimore, Md., 21206 Kim Brisbon/Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 01-08-13 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C 1206 W NO I C BROWN COM NORTH AVENUE COMMUNITY FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ac Due to (or as a consequence of): mon Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown

Physician /Medical Examiner

permit. Pages 1 and 2 Depertment of Health a Important: If item 27 is any Injury or other trai once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Directo

Funeral

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Be ပ

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, in a Modical Examinar must be notified at

72 hours after death with

12 should be filed within 7, th and Mental Hygiene.
7 Is marked other than "n

Baltimore, Maryland 21215-0036

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Box 68760,

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Division of Vital Records,

physician and s the buriat-transit as jo certificate has

Exam Physician/Medical Completed by Be Certification: To

Medical

State Registrar

within 24 hours after death

To the Funeral Director: After this certific completely filled in by the funeral director, i To the Hospital within 24 hours a To the Funeral I Hospital

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										24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No		topsy findings availa completion of cause of
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon							n (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify)			
Z Accident	estigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes	2 □No	280	. Describe how injury	occurred	
	uld not be ermined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f.	Location (Street and City or Town, State)	l Number or Ru	ral Route Number,		

29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

osler stive Towson, mazzula

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAYAMT HIRPARA MORE 75.05

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:22 pm HAROLD BARR N 2105 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death of Baltimore Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 072-18-7053 Director 1 X M 2 □ E 03/04/1921 CTth and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28e-f show traumatic event, the Medical Examinat must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TyrYes 2 ☐ No N/A BALTIMORE Known as ! Harold Barr 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3031 FALLSTAFF ROAD, #603 21209 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Year or Dates WHITE 15. Decedent's Education ify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CERAMIC ENGINEER NUCLEAR SCIENCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **BARR** FRIEDA GOLDA. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Depertment of Heelth ar Important: if Item 27 is any injury or other trau BARBARA BARR/WIFE 3031 FALLSTAFF ROAD, #603, BALTIMORE, MD theirt) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM 12/24/2012 REISTERSTOWN, MD 21. Synature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Missell 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine due to (di as a consequence di) or Attending Physician: The law requires that the death certificete be executed nding physician and use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 4 Pregnant at time of death Day 5 Other (specify) signed by the at the detached for ☐ Yes 2 ☐ No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ mell, tus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been Recurrent Small bowel Obstructions 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has page 2 autopsy performed? After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ To the Hospitei or Attending Physiwithin 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year)

State

Registrar

M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McGinley

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31. Date filed (Month, Day, Year)

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Sinai Hospital of Baltimiru

December 22 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MA MAISON ASSISTED LIVING NOTTINGHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year, 9/25/1921 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Min 185-18-1157 Director 1 M 2 X F PENNSYLVANIA 91 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland at Director notified 28a-f 1 Yes 2X No MD BALTIMORE NOTTINGHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ms 23a or must be r Funeral USA 21236 9412 BELAIR ROAD "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: WHITE Specify: 3 X Widowed 4 Divorced Year or Dates ed other than "natu event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha RECEPTIONIST APARTMENT COMPLEX 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked o traumatic eve ပ MARY UNAVAILABLE JOHN MARNELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 GREENTREE VILLAGE LEBANON, PA ROBERT J. BAKER, III/SON item 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial, 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 12/26/2012 CATONSVILLE, MD 4 Donation 5 Other (Specify) 21. Signatus of Funeral Septice Lice 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P.A. TOWSON, MD 21286 8521 LOCH RAVEN BLVD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con vouence of **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury the bunal-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has autopsy performed) 2 Z No this certificate Yes director, 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) DVILVIU IVAIGICACCA ၉ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: 1 Natural After injury 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20, 2012 12:45 PM Tema Burns December Rave Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Mont gomery Takoma Park Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Director 076-34-8166 1 M 2 X F 69 Feb. 5, 1943 New York Usual Residence of Decedent Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho f Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f sho: other treumatic event, t<u>he Medical Examiner must be notified at</u> or 28a-f shov 10a, State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Montgomery Silver Spring 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Copley Lane 20904 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 XMamied 1 Yes 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Realtor Real Estate 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Davis Evelyn Pulver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Copley Lane, Silver Spring, MD Sidney Burns / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Coremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 12/22/2012 Beltsville, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD Signature of Funeral Service Licensee M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between URCINOMA Immediate Cause (Final STAGE Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TO PENIA ANIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy eral Director: After this certificate I filled in by the funeral director, peg 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier icense number 29d. Date signed (Month, Day, Year) 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON SHAMIN ADVENTIST SHALLIND 31. Date filed (Month Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2012 Physician/ 5:15 A M Dorothy Pauline Berry Dec. 19 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Hospice Ctr. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Director 410-44-1214 1 M 2 X F June 10,1931 Virginia Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2XXNo MD Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a United States 21224 500 Southern Avenue or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes Give Specify. "natural", White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 8 Years permit. Page 1 and 2 should be filed w Department of Health end Mental Hygl Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2012 ည Sarah Miller Baker Sweeney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1627 Cape May Road Baltimore, Maryland Barbara D. Gattus (Daughter) DECEMBER 19, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 St Burial 2 Cremation 3 Removal from State 12/22/2012 Baltimore, Maryland ■ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service License Dennis 22 Name and Address of Facility al Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami use as the burial-transit Cause (Disease or Injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physicien page 2 should be detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DOROTHY 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No After this certificate Yes 2 N funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE 1 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending n 24 hours after death.

• Funeral Director: Aft bletely filled in by the fur 1 Tes 2 No 2 Accident Investigation 3 D Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day,

/DV

Registrar
DHMH 17 Rev 06-2011

State

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 2)a) (Type, Print)

CRNP

32. Registrar's signature

MORGAN,

31. Date filed (Month, Day, Year)

26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nancy Travers Dryden Baker 2012 December 18, 9:40AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4504 Morgal Street Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 579-54-1827 1 □ M 2 🗓 F Yrs 72 Usual Residence of Decedent September 12, 1940 Washington, D. C. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 72 hours after death with the Maryland 10a. State 10b County 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4504 Morgal Street 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces ٥. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3

Widowed 4 □ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Education permit. Page 1 and 2 should be flied wi Department of Health and Mental Hygie Important: If Item 27 Is marked other any Injury or other traumatic event, II Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Libbie Travers <u>Hugh L. Dryden</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jean Edmonston/ Step Daughter</u> 33119 Lighthouse Road, Selbyville, Delaware 19975 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mcemetery, crematory or other place) 1 ☐ Bunal 2 ☒ Cremation 3 ☐ Removal from State December 20, 2012 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland <u>Crematorium,</u> 21. Signature of Furieral Service Lice 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 Inc. 300 Maryland M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Weeks Dehydration Medical resulting in death) Due to (or as a consequence of): Examiner Metastatic Breast Cancer l Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): cate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Dav 1 Yes 2 ¥ 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The lew requires to hours after death.
Funeral Director: After this certificate has been sign Diabetes, Hypertension, Hyperlipidemia 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Osteoporosis autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 A Natural
2 Accident 5 Pending 1 Yes 2 No Investigation
6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Medical 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Someta no D27301 December 18, 2012

15 M

Registrar
DHMH 17 Rev 06-2011

615 West Montgomery Avenue, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 6 2012

M.D

32.

Registrar's Signature

Douglas Shumaker

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Crowell Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Examiner Union Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 215-60-3808 Country) Director 1 X M 2 □ F 60 03 05 52 MD 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MID NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2803 Winchester Ave 21216 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1X Never Married 2 ☐ Married ☐ Yes 2 X No Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify If Yes, Give Specify: Black 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>10t</u>h grade Cook Country Kitchen na 1 and 2 should be filed w if Health and Mental Hyg item 27 Is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Crowell Annie Burges 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Evatt Ct., Randallstown, Md 21133 19a. Informant's Name/Relationship (Type, Print) Raleigh Crowell-Brother Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Mt. Zion 12/28/2012 Baltimore, 21. Signature of Experient Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore, 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Anoxic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Matural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certified 29c. License number 19/2012 T2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21218 Parkway East Gabriela Molena 201 University 31. Date filed (Month, Day, Year) State Registrar

<u>0</u>

Division of Vital Records.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 23a.pt.11.per phy, g934 12-26-12 Sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:44 AM Gabriela Frances Cain Jecc 760 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Hours Director 218-44-8217 1 □ M 2 🔀 F Maryland Dec. 5, 1944 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 🖎 No Maryland | Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number with or items 23a Funeral 1309 Scottsdale Drive Unit Q 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u> Vocational School Director</u> Dental permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Gabriela Jancuk Melvin Theodore Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Wagner Way, Forest Hill, MD 21050 Daymond T. Cain / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Rose Hill Svcs, LLC 12-14-2012 Bel Air, Maryland 4 ☐ Ponation 5 ☐ Other (Specify) 21. Signatural Funeral Service Lio Service McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ now disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner erc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (a a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day been signed by the s should be detached 9 Unknown 9 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? ≦ 7 7 Yes 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? has a Hospital or Attending Physician: The 124 hours after death.

e Funeral Director: After this certificate I letely filled in by the funeral director, pag lassiv 1 ☐ Yes 2 ☐ No Pneumonia 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1/ Natural 5 🗆 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Director completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practition or 1. the best of my knowledge, death occurred at the time, date and place, and the to the cause(s) and manner as stated. 29a. Certifier (Check the unity unie) 29b. Signature and title of 29d. Date signed (Month, Day, Year) w122012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed Month, Day, Year) State 26 Registrar

COC 21-21-

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ellint Cines 12 2012 1300 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Landow House 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min (Month, Day, Ye 8-23-1926 Country) New York 1 X M 2 🗆 F 056-24-2880 86 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 13125 Cleveland Dríve United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1945
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: 3X Widowed 4 □ Divorced 1946 White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Liquor Store Retail Store Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leah Agress Charles Goldstein

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David Mem. Gardens

Pnysician/ Medical Examiner

19a. Informant's Name/Relationship (Type, Print)

4 Donation 5 Other (Specify)

1 💢 Burial 2 🗌 Cremation 3 🗖 Removal from State

Lawrence Cines - Son

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC 2 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Damion Doyle, MD - 1801 E. Jefferson St. Rockville, Maryland 20852

20a. Method of Disposition

attending physician and for use as the burial-transit within 24 hours after death.

To the Funeral Director After this certific completed filled in by the funeral director, it

has

Division of Vital Records, P.O. Box 68760

	21. Signature of Funeral Servic Mensee	Edward Sagel	22. Name and Address of Facility 1091 Rockville Pike,	Edward Sagel Fo								
	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c Immediate Cause (Final disease or condition		enter the mode of dying, such as care			Approximate Interval Between Onset and Death						
	resulting in death)	Due to (or as a consequence of): Hypertension										
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence oi).										
lical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):										
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	i. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3		23d. Date of de Month	elivery Day Year						
ed by Ph	Part II. Other significant conditions contri	ibuting to death but not resulting in t	the underlying cause given in Part I.			o the cause of death? Probably 4 🗆 Unknown						
omplet				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 No						
Be (25. Was case referred to medical examiner?		26. Place of Death (
	1 ☐ Yes 2 🗶 No	spital: 1 Inpatient 2 ER/Outp		ng Home 5 🗆 Residence	6 X Other (Spec	ed Living cify)						
ficate:	27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Tin inju		28d. Describe how injury occurred								
Aedical Certificate: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street a City or Town, Sta		ıral Route Number,						
Nedica	(Check 2 Medical Examiner:	: On the basis of examination and/or i	eath occured at the time, date and place nvestigation, in my opinion, death occur dge, death occurred at the time, date an	red at the time, date and pla	ce, and due to the	cause(s) and manner stated						

29c. License number

D0057884

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13125 Cleveland Drive, Rockville, Maryland 20850

Date

12-23-2012

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

121/12

12

Falls Church, Virginia

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41613 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Helena Dec. 2012 Anne Carnes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 601 Maiden Choice Lane Catonsville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months Hours Director 215-80-9607 1 M 2 X F Yrs. 90 July 24,1922 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 🗌 Yes 2 🖾 No Baltimore Catonsville ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Maiden Choice Lane 21228 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: If Yes, Give Completed 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental ! ant: If item 27 is marked o Sullie Cullinane Henry Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1902 Willow Spring Road Dundalk, MD 21222 (Niece) Frances B. Parker Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or once. Sacred Ht. of Jesus Cem. 12/21/201 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Maryland Signature of Funeral Service Lionee Johnny Gibbs 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part fenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ATERAL TWO MONTH Medical Due to (or as a consequence of): Examiner DROPHARYN Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury FOUR MONTH Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUGIVE LUNG DISEASE, SLEEP APNOFA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown SYNDROME, TYPE I DIABETE MELLITUS. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has HYPERTENSION. PULMONARY HYPERTEND perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (C. C. Vonê) Be examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one K. Dang MD D0018362 Name and address of person who completed cause of death (Item 23a) (Type, Print) K-Dang 3455, Wilkens Are Stellio, Baltimore

State Registrar 31. Date filed (Month, Day, Year) 012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 21. Physician/ 2012 2:04 PM Shannon Carr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 578-40-5326 **Director** 1 X M 2 □ F 83 Vrs Sept. 22, 1929 Maryland Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Tyes 2 X No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 20878 11805 Longdraft Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 X Married ☐ Yes 2 🛛 No þ Maryland 21215-0036 1 ☐ Yes 2 🕅 No White If Yes, Give Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Customer Relations Post Office : If item 27 is marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H should be Elsie Ravenscroft Samuel Alexander Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh Iment of Health a tant: If item 27 is 20878 11805 Longdraft Court, Gaithersburg, Maryland Beatrice P. Carr/Wife 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) January 2013 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or Rockville Cemeterv Rockville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc.
300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service License M01173 untha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final Sepsis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease exacerbation Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Pulmonary Embolism burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical as the l Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death detached 9 Unknown à Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? certificate has 1 ☐ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) æ 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No ည 1 Npatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 ☐ Yes 2 ☐ No decth. 2 Accident
3 Suicide
4 Homicide Investigation in by the Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, fter To the Hospital of within 24 hours aff filled Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying, Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Shanthu Nadar, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrans Signature

29c. License number

D70241

8600 Old Georgetown Road, Bethesda, Maryland

29d. Date signed (Month, Day, Year) December 21, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year 2012 Physician/ Alan Lewis Dessoff 1:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac Manor Care Potomac If Under 1 Year
Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. Social Security Number **Funeral** Hours Min 193-28-4217 Director 1 X M 2 D F Washington, OC 8-11-1935 Yrs Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shou ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director Bethesda 1X Yes 2 ☐ No Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20814 6024 Chatsworth Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1959 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No 1960 Specify Specify. White 3 Divorced Year or Dates 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Journalism Journalist 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Augusta Silverman Joseph Dessoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Park Avenue, New York, New York 10075 Regina Kessler - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Garden of Remembrance 12-16-2012 Clarksburg, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Brian Deibler Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Metastatic Squamous Cell Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir sician and burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 as the L attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the a ld be detached f g 🔲 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been signal director, page 2 should l prior to completion of cause of death? 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 🛛 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 🗌 Yes 2 K No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 24 hours after death.

Funeral Director: After this letely filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accider
3 Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🛴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 1 only one)

State Registrar 31. Date filed (Month, Day, Year)

DEC 2 6 2012 Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

pmas

Thomas Masterson, MD - 6801 Whittier Avenue, #205, McLean, Virginia 22101

29c. License number

D50534

29d. Date signed (Month, Day, Year)

12-13-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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P	filed via Hyginal distribution	To Be	17. Father's Name (Fi]		ner's Nam nie Ax	e (First, Middle elrad	e, Maider	n Surname)		
Maryland 21215-0036	d Men d Men merks	_	Albert Scha		e Print)			19h Mailii	na Addres	s (Street a			al Route Numi	per, City o	or Town, Sta	ate, Zip	Code)
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Baltimore,	permit. Page 1 end 2 should be filed within 72 hours eftar deeth with the Maryland Dapertment of Haaith and Mentai Hygians. Importent: If Item 27 is merked other then "neturel", or Items 23e or 28a-f show importent: If Item 27 is merked other then "medical Examinat must be notified at eny injury or other traumetic event, the Medical Examinat must be notified at 000ce.		20a. Method of Oispo	sition	Removal from	n State	C	lace of Dispo emetery, crea	natory or	other plac			Oate		Location - C		
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Box 687	cartifice	an/N	IF FEMALE: 23b. Was decedent p in the past 12 n	pregnant		e Birth 2	□ Feta	al death 3	☐ Ectopic	pregnan	су				23d. Oate Mor		very Day Year
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<u>P</u> .	Attending Physician: The lew requires thet the daeth cartificete be exacuted in death. ector: After this cartificata has baen signad by tha attanding physicien end by the funarel director, paga 2 should be dateched for use es the burial-trans	Completed by Physician/Me	Part II. Other signifi	cant conditions co	entributing to	death bu	t not res	sulting in the	underlying	g cause g	ven in Pa	ırt I.					the cause of death?
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Division of Vital Records,	al or A saftar i Directed		4 Homicide	determined	bui	lding, etc.	. (Specif	y)						Town, St			
_	To the Hospital or Attending Phy within 24 hours aftar death. To the Funeral Director: After thi complataly fillad in by the funarei	Medical	101 1 0	Certifying Phy Medical Exam	and On the l	annin of av	aminatio	on and/or inv	etigation	in my ooir	non death	n occurred	at the time, da	ue and pi	ace, and due		Jauso of and The mor brands
	thin 2 the F	Ž	only one) 3 29b. Signature and	☐ Certifying Nur	se Practition	ner: To the	best of	my knowledg	e death o	9c. Licen	the time,	date and	olace, and due	to the ca	Date signed	idili ici a	S Stated.
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	•		30. Name and addr	ess of person who	completed ca	ause of de	eath (Ite	m 23a) (Type	, Print)	les:	n		0	2004	7		
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 Decedent's Name (First, Middle, Last) 2. Date of Death December 21, 2012 Physician/ 10:40 AM Elinor Davis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stanmore Road Baltimore Baltimore 9. Birthplace (State or Foreign Country) Mary Land Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 2/26/1932 Days Hours Min. 215-30-8561 80 Director 1 □ M 2 🖺 F or than "natural", or iteme 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director Baltimore Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 184 Stanmore Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XXNo Black White etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 XNo Specify: specify: White 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home e 1 and 2 should be filed wit of Health end Mental Hygie If item 27 is marked other or other traumatic event, It Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Henry John Kohles Gladys Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21212 Mary Ellen Mattes / Daughter 184 Stanmore Road Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Depertment of H Importent: If ite any Injury or ott 1 X Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 12/27/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Juneral Septice Licenses 1050 York Road Towson, Maryland 21204 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Paucrealie Physician/ Cauces Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificete I 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 📈 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) မှ 1 ☐ Yes 2 K No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Desember 22ND 2012 D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21204 Sul 4105 6701 N Charles Street ABBAS MD 32. Registrar's signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #2 &29d Per PHY G934 12/26/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 Physician DEC Ronald W. Emerson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Courtland Gardens Nursing and Rehab Center Pikesville Baltimore Date of Birth
(Month, Day, Year)
10-22-1944 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Days Hours X□M 2□F 68 LA 212 44 4339 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State fshow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. and them 27 is marked other than "natural", or items 23a or 28a-f show any, or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Pikesville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 USA 8205 Autrim Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Y☐ Yes 2☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 No Specify: African-American Baltimore, Maryland 21215-0036 Specify 2 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Emerson Myrtle Baptiste ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sybil Woodard/Sister 5620 Elderon Ave., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1∭ Burial 2 □ Cremation 3 □Removal from State permit. Page Department of Important: If any injury or once. Garrison Forest Veterans | 12-20-2012 Owings Mills, MD 4 □ Dentation 5 □ Other (Specify) 22. Name and Address of Facility Vie Funeral Home P.A. of Baltimore Co. 21. Si nature of Fun ral Service 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final Lu -Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 200 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 **20**00 2 ☐ No 1□ Yes 1 ☐ Yes Hospital or Attending Physician: by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 1 ☐ Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident af e death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral Di completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 32. Registrar's St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	Marylan	id / Depa <i>Cei</i>	artment of <i>tificate of</i>	Heali Deat	th and N th	/lental Hy	/gien Reg. N	2012	2 4	1619
	Physicia		1. Decedent's Name (First, M 8essie C. Eisen								2. Date of Domestin Month 12)ay Year 3 201		ime of Death
, and a large	Medic Examin		4a. Facility Name (if not institu	tion, give st				4b. City, Town,		ion of Death	12	4	c. County of Dealortgomery	ath	
	Funeral		Hebrew Home of 5. Social Security Number	6. Sex	7.	Age (In yrs. I	ast birthday)	If Under 1 Yea	r If Un	der 24 Hrs.	8. Date of Bi	rth	9. B	rthplace (S	State or Foreign
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980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Divo	Married	Was Decede Armed Force Yes 2 If Yes, Give Year or Date:	es? XNo	1	Nas Decedent of fYes, specify Cu	ban, Mex	ican, Puerto	ecity Yes or No Rican, etc.)	-	14. Race - Am Black, Whi Specify:		ian,
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Baltimore, Maryland 21215-0036	should n and M 7 is mai raumat		19a. Informant's Name/Relat		e, Print)			ng Address (Stree						ip Code)	
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timo	t. Page tment c rtant: If		1 🗶 Burial 2 🗌 Crema 4 🔲 Donation 5 🗆 Oth	er (Specify)		Nat	ional Ca	natory or other pa apitol Heb	rew	i .	-2012	_	itol Heig		
Ba	permit Depar Impor any in	Į.	21. Signature of Funeral Serv	ce Licensee	Edward	Sagel		. Name and Add 191 Rockvi			_		uneral Dir /land 2085		ח
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Division of Vital Records,	sician: The law rec certificate has bee irector, page 2 sho	Completed by									24a. Was auto perf 1 \(\sum \text{Yes}\)	opsy ormed?	prior to death?	completio	dings available on of cause of
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on of \	Attending Phy r death. sctor: After this by the funeral o	Certificate: T	27. Manner of Death 1 Natural 5 Pe 2 Accident Inv	estigation	28a. Date of		28b. Time of injury	28c. Inj			28d. Describe			СПУ	-
ivisi	l or Att after d Direct			uld not be ermined		Injury - At ho etc. (Specify		eet, factory, office	9		28f. Location (City or To		nd Number or R e)	ural Route	Number,
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1			A. Chilako	amas	ri WZ	> 61	21 M	on tose	Rd	Pa	ockvi)	le	MD 2	08	52
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 35AM 0 2011 Medical ecember 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie Iting Washington Medica ial Security Number 6. Sex 17. Ac Hone Glen runde Social Security Number If Under 1 Year I If Under 24 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Days (Month, Day, Year) Hours 220-56-1240 60 Director 1 ፟፟ M 2 ☐ F March 15,1952 Maryland permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho er than "natural", or items 23a or 28a-f showing Medical Evaniner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 7807 Mallow Ct. 21122 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. Š 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗽 No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Parts Manager Automotive Dealer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Fox Jennie M. Dreese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly M. Wheeler / Daughter 835A Swift Rd., Pasadena, Maryland 21122 Date 24, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) De S 12 1 Burial 2 x Cremation 3 Removal from State injury or Metro Crematory, Inc. Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21. Signa ure at Funeral Pervice Litensee eny SIR 23a. Part 1/2 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Seps. S Pnysician disease or condition Medical resulting in death) as a cons viuence of) Examiner neumonia JOL Sequentially list conditions, if any adding immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulting in death least Examine signed by the attending physician end d be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Yes 2 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Drobably 4 ☐ Unknown Completed been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe Yes 2 Director: After this certificate has d in by the funeral director, page 2 1 Yes 2 1 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 🗆 Yes 2 🗆 No 5 Pending 1 Natural Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined hours within 24 hours of the Funerel Completely filled Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier the 29b. Signature and tiffe of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) te Uti 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8.per fh.g936 2-4-13 sm State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -20/3 9:35AM ate Medical Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death imon Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birtin (Month, Day, Year) 1940 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min Director 1 □ M 2 🖼 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is an arted other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No imore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 916 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 þ ☐ Yes 2 No 21215-0036 1 Yes 2 No Specify. 3 Divorced If Yes, Give Specify: Mack Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) condary (0-12) Elementary/Se College (1-4 or 5+) lectronics Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) ည 19a. Informant's Name/Relationship (Type, or Rural Route Number, City or Town, State, Zip Code) VICCE MD 2/1/2 lary simore, 21 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State DECEMBER 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 21212 23a. Part 1. Enter the dise te, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that in the control of the control Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 HESTER FREDERICK IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 <a>D Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 ☐ Other (specify) signed by the ar 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 호 cate has been sig page 2 should b Completed 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy After this certificate 1 Yes 2 No 1 ☐ Yes 2 🗶 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural 5 Pending Accident
Suicide M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TRACIE L. MORGAN CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sharon Fares Dec 2012 9:35 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Co. Upper Chesapeake Hospital Rel Air If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 6. Sex Director 236-66-9740 1 □ M 2 🗓 F Oct. 5, 1944 68 West Virginia Usual Residence of Decedent permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantina that be netified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford 1 ☐ Yes 2 🖾 No Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 510 Eastview Terrace 21009 United States Apt. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married ρ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 😾 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9 Years Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Goldie E. Coffman William J. Wickline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Old Orchard Road York, PA 17403 Richard D. Fares, Sr. (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Surial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns. 12/21/2012 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Michael Neiser Duda-Ruck Funeral Home of Dundalk, ichas 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) obstructive mon c Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consuluence of): Examir Hospital or Attending Physicien: The lew requires that the death certificate be executed 24 hours after death, Funeral Director: After this certificate has been signed by the attending physicien end Cause (Disease or injury sate has been signed by the attending physicien end page 2 should be detached for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Year Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 N Yes 2 🗆 No Be (**Division of Vital** director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 🗗 No 1 Inpatient 2 I ER/Outpatient 3 I DOA **lirector:** After this in by the funeral Certificate; 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft To the Funeral DII completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death and place 3 Certifying Nurse Practitioner: To the basis of my knowledge death occurred at the time date and place. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Bel Air Shakoor MD South

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Registrar

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31. Date filed (Month, Day, Year)

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December

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32. Hegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Earl Marshall Foster Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Min. (Month, Day, Year) 12-29-1937 Country) Maryland Hours Director 216-34-1950 1 X M 2 - F 74 Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2438 Keyway 21222 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years and Dye Maker/Machinist other t Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked o traumatic eve P Earl George Foster Kathryn L. Snook permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane M. Foster (Wife) 2438 Keyway Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/28/2012 Baltimore, Maryland 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. who 7922 Wise Avenue Dundalk, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ KESPIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PULMONARY OBSTRUCTIVE HRONIC sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 M Other (Specify) 1 🗆 Yes 2 💆 No ဂ္ဂ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Hospital of 24 hours a e Funeral D Medical 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 06-2011

Registrar

SYED Q. ABBAS MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

6701 N Charles Sheet Seule 4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Gordon Month 12 Marie Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Annapolis Anne Arunde If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year Director 1 □ M 2 🕱 F Australia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 23a-f show many injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Severna Park Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Evergreen Rd ,,5, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. è 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. 3 X Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Goggins Eawara caith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ULO Americana Dr. Apt 34 Annapolis, MD Megan hordon-Hall Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Beltsville, chesapeake crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Cremation & Funeral Alternatives 22. Name and Address of Facility Robecco 8717 Green Pasturys Dr. Bauhmore, MD 21786 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lip. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Internal Cause (Disease or Internal Cause (Disease or Internal Cause (Disease or Internal Cause or Internal Cause or In Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attendion abundance. attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: res, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No Was ... autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 🗌 Yes Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) an 30. Name and address of serson who completed cause of death (Item 23a) (Type, Print) ANNAPILIS m) 2000 MEDICAL PKWY. State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 50 P M GORE 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LEVINDALE ALTIMORE Social Security Number f Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🕱 Months Min. (Month, Day, Year) 215148215 Director 29 08 Usual Residence of Decedent or 28a-f show 10a. State 10b. County important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2434 West Belvedere Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes, Give X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72. th and Mental Hygiene.
7 is marked other than "r ementary/Seconday (0-12) College (1-4 or 5+) 12th grade Homemaker House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Victor Grace Victor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Niece permit. Page 1 and 2 sh. Department of Health ar Important: If item 27 is 5301 Pembroke Ave, Baltimore, Md 21207 Doris Lawrence Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Constitution) 20c. Location - City or Town, State Date King Memorial Park 12/28/201 2 Woodlawn, Md 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21. Signat ire d Funeral Service Licensee 21215 Baltimore, Md 23a. Part 1 Enter the 1s, ase, or complications that ca. I be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail vr. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Breast disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or iinjury Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 🗷 No 3 🗌 Probably 4 🗀 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 2 1 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 🗹 No Other: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 🔲 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗹 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 2012

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

MARSHALER

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #8, per fh, g934 12-28-12 sm
State of Maryland / Department of Health and Mental Hygiene For State Registrar 41626 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2012 Nan E. Guillott 4:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) July Sept. 26 . 1 Country) 579-20-6262 **Director** 1 □ M 2 □XF Yrs 26 88 1924 Pennsylvania Usual Residence of Decede 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified</u> at 10b. Count 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Tyes 2 Tyno MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #K304 2525 Pot Spring Road 21093 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 □ Widowed 4 □ Divorced Specify: Year or Dates white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be filed Health and Mental Hitem 27 is marked of မ Harry Najarian Sophie Vassilian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31589 Charley's Run; Bethany Beach, DE 19930 John W. Guillott, Jr. son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1: Department of I Important: If ite any injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem Gardens:12/27/2012 Timonium, MD 21. Signature of Funeral Service 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition UROTHELIAL CARCINOMA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director. ospital or Attending Physician: hours after death. uneral Director: After this certific **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 K Other (Specify) HOSPICE1 ☐ Yes 2 😿 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 12012 30275 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 6 2012 Registrar

4:50 а.ш.

DECEMBER

GUILLOTT

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Steamon Junior Hardin 12:31 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rosedale If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 245 68 4628 68 Director 1 🛭 M 2 🗆 F July 12, 1944 Maryland er then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 ☐ Yes 2 🎦 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Haner Funeral 310 Savannah Rd. 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ۾ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates American 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Completed Indian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Mill Mobile Equipment Operator Be ğ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ance. Steamon Barry Hardin Berlie Mae Brewington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Carrie Hardin (Wife) 310 Savannah Rd. Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State North Lumberton, Carolina Bethel Hill Church Cem. 12/29/2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex lokn W Maryland 21221 23a Jart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) oronan Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 ☑ No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ဍ 1 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 Fran 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day OS AM MARV Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Morellashira If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) -32-5420 Director 1 🗆 M 2 😿 F 90 01/1922 PENNSYLVANIA nit. Pege 1 and 2 should be filed within 72 hours after death with the Meryland sertment of Health end Mental Hygiene. Sortant: If item 27 is marked other than "netural", or items 23e or 28e-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral CATHERINE 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK Specify. 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY Elementary/Secondary (0-12) College (1-4 or 5+) 3chools CROSSING GUARD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GEORGE permit. Pege 1 and 2 should be Depertment of Health and Men Important: If item 27 is marke any injury or other traumatic. once. TORRANCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 19a. Informant's Name/Relationship (Type, Print) DAUGHTER I RD., MILLERSVILLE, ONDORIA 435 OLD MI HARMON- AISTON MARVIANCE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stat 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 27/2012 BALTIMORE, MARYLAND ARBUI 22. Name and Address of Facility E PERRICK C. JONES FIH, P.A.
+611 PARK HGTS, AVE. BALTIMORE, MARYIAND 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Appro mate Interval Between Onset and Death Immediate Cause (Final Priysiciani disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The lew requires that the deeth certificete be executed ettending physician end I for use es the burlel-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) After this certificete has been signed by the signeral director, page 2 should be detached g 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ 1No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident after death Director: / Investigation 3 Suicide 6 Could not be To the Hospitai or Atte within 24 hours after de To the Funeral Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or investigation in manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12012

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOLE

2 6 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#20b State of Maryand 2026 and Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HRISAFINAS Physician/ December Day HENRY 06:25AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death HOPILIN tospita Dre ecurity Number If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min. -42-2974 Director 1 M 2 F Greece 46 Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other then "neture!", or items 23e or 28e-f show ury or other treumetic event, Ite. Wedforl Exemples must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral 2122 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, NAS Baltimore, Vidlage Cem. 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny finjury or once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Se 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cholongio carcin omo Intrababatic disease or condition resulting in death) Medical Due to (or at a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) director, page 2 should be detached for use as the buriel-transit Hospital or Attending Physician: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): After this certificate has been signed by the ettending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day 5 Other (specify) 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deeth.

To the Funerel Director; After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifie 29c. License number Shadrank Gorg MBBS RES - 000 DECEMBER, 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) SHASHANK GARG. 1800 OF LEANS ST. Dalt-more 31. Date filed (Month, Day, Year) State DEC 2 6 2012 Registrar

DHMH 17 Rev 06-2011

			For State	•	partment of Health and N	Nental Hygien	е
			Registrar		ertificate of Death	Reg. N	·2012 41630
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	Examir	ner		of Baltimore	4b. City, Town, or Location of Death Baltimore Ci	ty.	c. County of Death
	Funeral Director		5. Social Security Number 210-20-8670 Usual Residence of Decedent	7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) 6 BA HO, MI)
	Aeryland Ba-f shov tified at	ector	10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	s 23a or 2	Funeral Director	10e. Street and Number 6922 Dig by R	OAd	10f. Zip Code 2/20/	10g. (Citizen of What Country?
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Baltimore,	Pa He Fr		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State cemetery, or Wood	ematory or other place) 12/	29/12 B	Location - City or Town, State A Ho, MD
Ba	permit. Depertr Importr eny inji		21. Signature of Funeral Service License	greene 1	22. Name and Address of Facility VAC 8728 Liberty Kor	ighn C. G	reene 115 HOWN, MD 21133
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Divisi	Hospital or Atten 24 hours after deal Funerel Director: stely filled in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
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	To the within 2 comple		29b. Signature and title of certifier	(6.72 G	29c. License number		ate signed (Month, Day, Year)
			Arshpreet Ko		RES-000	Dec	lember 18, 2012
			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type IR. MBBS - Sinai	. Print) Hospital of Balt	20104 0	
	Stat	e	31. Date filed (Months Pay, Year)	32 registrar's Signatu	Tuspiece of ball	ir ruck.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Peter Anthony Halp	ert S 1- For State Registrar	tate of Marylar		rtment of tificate of		nd Ment	al Hy		eg. No. 20	112	41	631
Physician/	Decedent's Name (First, Mid	dle,Last)					2	Date of Dea Month	nth Day Yea er 17, 2012		 Time of D 2218 ht 	
Medical Examiner	Peter Anthony Ha 4a. Facility Name (if not institut		her)		4b. City, Town, o	or Location of	f Death	Decembe	4c. County	of Death	2210111	
	Interstate 270 NB so				Frederick				Frederic			
Funeral	5. Social Security Number	6. Sex 7	Age (In yrs. la	st birthday)	If Under 1 Ye		_	8. Date of Bi	rth (MM/DD/YYY)	9. Birth		or
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MD 12 shc th and th and 27 is	Toni Halpert - N	Jife					reder		ryland 217		- 01-1-	
or Heal	20a. Method of Disposition 1 Y Burial 2 Cremati	on 3 Removal from	n State C	rematory or other		.		Date	20c. Location			
Baltimore, permit. Pages I ar Department of Hee Important: If ite	4 Donation 5 Other	Specify:	Gar		emembrand			20-2012			, Maryla	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at noce To Be Completed by Furneral Director	21. Signature of Funeral Service	e Licensee Edwar	d Sagel		lame and Addre		Danz	ansky-G	oldberg Me Maryland	∍moria 2085:	al Chape 2	∋1
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certificate certificate anding physics as the bccian/Me	23b. Was decedent pregnant in past 12 months?	I I LIVE BII	th nt at time of dea	ath -	tal death ther (Specify)	BEctopic	pregnan	icy	Month	L)ay	Year
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To with To com	29b. Signature and title of cert	and manner sta ifier	ated.		29c. Lice	nse number			29d. Date sig	ned (Mo	nth, Day, Yea	ar)
	gretz.				0.6	C.M.E.			Decembe	г 18, 20	012	
	30. Name and address of pers					<u> </u>			1000			
	Ana Rubio M.D., Ph) W. Baltimo	ore Street,	Baltim	nore, MD 2	21223			
State Registra			gistrar's Signatu	ba	Kel							

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DOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 December 7:05 Alvin Hobart Harbaugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Montgomery Hospice Casey House If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 203-22-7769 Director 1 X M 2 □ F 85 30, 1927 Pennsylvania permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 X Yes 2 ☐ No Maryland| Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20851 1101 Wade Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?

1 Ves 2 No Unk.

If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hydroseeding Company Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garrett Hobart Irene Mary Burnworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ricky Harbaugh / Son 7004 Cypress Hill Drive, Gaithersburg, Maryland 20879 20b. Place of Disposition (Name of Parklawn Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State December 31 1 X Burial 2 Cremation 3 Removal from State Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Si nature of Furnit Sprice Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Robert A. Pumphrey Funeral Home, Rockville, 1900 West Montgomery Avenue, Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition **Enysician** Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) Hospice 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation 6 Could not be 2 Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 A Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Debrah Miller, 31. Date filed (Month, Day, Year) State Registrar

DEC

32. Registrar's Signature 2 6 2012 park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

R143201

6001 Muncaster Mill Road, Rockville, Maryland 20855

12.22.12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6130 Amos Isei 2018 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min. **Director** 577-06-2394 1 🕅 M 2 🗆 F 63 Aug. 23,1949 Nigeria Usual Residence of Dece ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Prince George's <u>Springdale</u> 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9605 Reiker Drive 20774 Nigeria 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: African "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Private Lawyer 5+Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Ikhai Isei Felicia Alogbuan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a David O. Isei/Son 98-711 Iho Place #504, Aiea, HI 96701 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/4/2013 Family Plot Afuzie, Nigeria 22. Name and Address of Facility J.B. Jenkins Funeral Home, Signature of Funeral Service Licensee Inc. 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Interval Between Immediate Cause (Final disease or condition Subdural hemotoma Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner HUPERTENSION Sequentially list conditions, the sequentially list conditions, the sequence of the sequence o Examine executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 09289 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day g 🗌 Unknown g 🗌 Unknown P.O. þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death.

I Director: After the din by the funera 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical within 24 hou

To the Funer

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar

31. Date filed (Mon

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

sistrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

00042183

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 11:55 A M ohnson 2012 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner BAHIMORE NA MEMORIAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Min. (Month, Day, Year) Director 12 M 2 D F 67 DEC. 10-1945 South CARolina or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c . City, Town or Location Director 1.2 Yes 2 ☐ No MARULANO 4/HMORE 10f. Zip Code 10g. Citizen of What Country? 15A 21202 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Fream American Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kin of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) RUCK DRIVER Be 17. Father's Name (First, Middle, Last) should be file and Mental H bhnson 18 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is any Injury or other trau BAHIMORE John son Court TUPPIN Harulana Baltimore, od of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date matory 1 Burial 2 Cremation 3 Removal from State or other place LAnsdowne, HARYLAND DEC. 29,2012 Zion 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Nancy M. Wallace Funeral Service 3404 W. Franklin Street Baito, Mar ure of Funeral Service Ligensee Sign maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Respiratory Distress syndrome Immediate Cause (Final Priysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Finter Indentying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 L Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been siç ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No After this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2. No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Natural
2 Accident 5 Pending injury Division 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The defice of Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2438996 December/22/2012 East university park way 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 RABEA SHAHEEN MD union memorial Hospital Baltimore, MD 21218 31. Date filed (Month, Day, Year)
DEC 2 6 201 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day. 7:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death -0 1017 CATONSVILLE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Min. Director 212-14-0793 1 🛛 M 2 🗆 F 94 07/06/1918 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE RANDALLSTOWN 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8608 WOODSPRING ROAD 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ACCOUNTANT ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SAMUEL **JAFFE** HILDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHEABEL JAFFE/WIFE 8608 WOODSPRING ROAD, RANDALLSTOWN, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ARLINGTON CEMETERY-CHIZUK AMUNO CONG. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/23/2012 BALTIMORE, MD Simulative of Funeral Service Licelis 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ - ci disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner OVESSIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi CITEMAYA that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No eral Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate; To Be Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide hours after City or Town, State) To the Hospital o within 24 hours af To the Funeral DI completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier De233710 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) John TAKO IV merson 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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erell King		State of Maryland / Department 1-For State Certificate		ygiene	2012	4163
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ledical Exami				Month December	Day Year 16, 2012	0853 hrs
		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		_ ,	(MM/DD/YYYY) 9. Birthp	place (State or
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any.		10a. State 10b. County 10c. City, Town or Lo				Od. Inside City Limits
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MOF Pages ent of nt: If		1 Burial 2 Cremation 3 Removal from State crematory of American State Crematory of Ame	EMORIAL PARK 12	24/12/	BALTIMO	RE, MD
Baltimore, MC permit. Pages and 2 s Department of Health a Important: If item 27 injury or other traum.		21. Signature of Fungral Service Licensee	2. Name and Address of Facility /AUGHN C. GREENE	E FUNE	RALSERV.	
Physician		28a. Part I. Enter the disease, or complications that caused the death. Do not enter	405 YORK RD.	BALTU	MD ALCO	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Alcohol and Methado</u>	ne Intoxication		g	Between Onset and Death
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876(pificate ng phy us the b	I/M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregna	ncy	23d. Date of delivery Month Day	y Year
Box 68760, edath certificate be the attending physicied for use as the buring of the buring the bur	Physician/Medi	past 12 months? 4 Pregnant at time of death 5	Other (Specify)			
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Reco	E			perform 1 ✔ Yes 2		2 No
tal Rec	Be C	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FR/Outpati	26.Place of Death (Check of			
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Division tal or Attendii sa Birector: A	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.	28f. Location (St	reet and Number or Rura ate) 923 E. 37tl	Route Number, City
Di Spital hours a neral 1		4 Homicide determined (Specify) Fd: Private 29a Certifier 1 Certifying Physician: To the best of my knowledge death or		<u>Baltimor</u>	e.MD.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	lical	one) 2 Medical Examiner: On the basis of examination and/or invest				
S Witt	Medi	and manner stated. 29b. Signature and title of certifier	29c License number		29d. Date signed (Month	, Day, Year)
		in hi -	O.C.M.E.		December 17, 201	2
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltin	nore Street, Baltimore. MD 21	223		
St	ate		are			
Regis	trar	DEC 40 LUIZ Brown p. 19	- F 1/4			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ 2012 Louise Keller 7:58 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery Manor Care Nursing If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Min. Days Months Director 577-30-2660 1 🗆 M 2 🔼 F 99 West Virginia 9-17-1913 Usual Residence of Decedent "naturel", or Items 23e or 28a-f show sideal Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Potomac Montgomery 1 K Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 10714 Potomac Tennis Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ 1 Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Liquor Merchant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental | 27 is marked c traumatic eve Mental Pe Rebecca Goldstein permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any Injury or other traumatic. Samuel Liebman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Lee Bukatman - Daughter 7700 Ivymount Terrace Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King David Mem. Gardens 12-26-2012 Falls Church, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility **Brad Smetzer** Edward Sagel Funeral Oirection 1091 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ As iration Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Oysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ending physiclan and use es the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month sate has been signed by the a page 2 should be detached? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 X Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Investigation To the Hospital or Atter within 24 hours after des To the Funerel Director completely filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 06-2011

State

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MI

DEC 2 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Miller, MD - 8218 Wisconsin Avenue, #305, Bethesda, Maryland 20814

Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D35579

29d. Date signed (Month, Day, Year)

12

23

2017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2012 Physician/ Frieda Kellerman 3:20 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brookeville Brookeville House 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days Hours 130-12-1413 Director 1 🗆 M 2 🗶 F 4-29-1919 New York ifiled within 72 hours and the Hygiene.
ed other than "natural", or items 23e or 28e-f show est other than "natural" or items 25e or 28e-f show event, the Wedical Examinar must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Director Severna Park Anne Arundel 1 🗌 Yes 2 🗖 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21146 549 Cypress Lane 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work aone life. DO NOT use retired) (Specify only highest grade completed) ve kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 1 end 2 should be filed with of Heelth and Mental Hygien Item 27 is marked other the other traumatic event, Item Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 David Tanenbaum Rose Birnbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra 549 Cypress Lane, Severna Park, Maryland 21146 Rochelle Pollero - Daughter 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1
Depertment of important: if it eny injury or o XBurial 2 Cremation 3 Removal from State 12-20-2012 Olney, Maryland Judean Memorial Gardens 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel Edward Sagel 1170 Rockville Pike, Rockville, Maryland 20852 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Dementia Years Medical Oue to (or as a consequence of): Examiner 2 Months Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). buriei-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ng physician e as the buriel Physician/Medical Hospital or Attending Physician: The lew requires that the death certificate be 124 hours after death.
Funeral Director: After this certificate has been signed by the attending physicia stely filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day 5 Other (specify) Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 ☐ Yes 2 🕱 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 5 Dending 1 X Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🛣 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-18-2012 R089866 KMKen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine Kemper-Dean, CRNP 18121 Georgia Avenue, #103, Olney, Maryland 20832

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) **DEC 2** 6 2012

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otate	Of Wary	Ce		of Death		•	Rea. No			
	Disconinia	/	Decedent's Name (First, Mid.	dle, Last)						2. Date of De	ath	2013) 3	Time of Pears 9
	Physicia Medic		Anna Kruger							Month 12	2	ay C. U Y ea f 1 201	2 3	:00 P M
AL.	Examin	er	4a. Facility Name (if not instituti		'			own, or Location				c. County of De Montgomer		
	Funeral		15101 Glade Orive 5. Social Security Number	6. Sex	#2A 7. Age (In y	rs. last birthday)	If Under 1	er Sprin	der 24 Hrs.	8. Date of Bir	_			e (State or Foreign
	Director		066-1D-8663	1 □ M 2 🕱 F		Yrs.	Months I	Days Hour	s Min.	(Month, Da 7-21-19	y, Year)		country)	o (otato or r oroigir
	d tow		Usual Residence of Decedent 10a. State 10b. Coun			Oit Town out				1-21-19		Ne	w Yo	
	a-f sh	cto		•		City, Town or Lo								Inside City Limits 1 ☐ Yes 2 🔀 No
	or 282	Director	MO Monto	lowerA	3	TIVEL Shr.	10f. Zip C	ode		1	10a C	itizen of What 0		
	s 23e c	Funeral	15101 Glade Orive	#2A			209				3	ted State	,	
	death r Item		11. Marital Status	Armed F	cedent Ever in Forces?	n U.S. 13.	Was Deceder If Yes, specify	nt of Hispanic Cuban, Mexi	Origin? (Spe can, Puerto l	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh		ndian,
Baltimore, Maryland 21215-0036	1 end 2 should be filed within 72 hours after death with the Meryland of Health end Mental Hyglene. item 27 is marked other then "neturel", or Items 23e or 28a-f show other treumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ M 3 🕅 Widowed 4 ☐ Divorc	If You C			1 ☐ Yes 2 l	M∑No Spec	cify:			Specify:	Whi	te
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<u>'lan</u>	l be fi fental rked tic ev	잍	Hyman Fishman						arah Col	,,				
lary	should end N is ma		19a. Informant's Name/Relation	nship (Type, Print)		19b. Maili	ng Address (S	Street and Nur	nber or Rura	I Route Numbe	r, City o	r Town, State, 2	Zip Code	*)
Σ	ealth m 27		Henry Lebowitz –	Son		4121	Sandcast	le Lane,	Olney,	, Marylan	d 20	832		
lore	ge 1 e nt of H : If ite or oth		20a. Method of Disposition 1 🗓 Burial 2 🗌 Cremation		m State	Ob. Place of Dispo cemetery, crea	natory or other	er place)	1	Date		ocation - City o	•	State
菲	permit. Pege 1. Department of I Importent: If it eny injury or of		4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Service			Judean Memo			<u>. </u>	7-2012		ey, Maryl		
Ba	permi Depar Impo eny ir		21. Signature of Furieral Service	Edwa	ard Sage							eral Dire land 2085		n
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		er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. ——	al Fibri	.llation							-	
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387			IF FEMALE:	22- 16										
Box 6	ath ce ettend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 🔲 Liv	utcome of pre e Birth 2 egnant at time	Fetal death 3	Ectopic pre				İ	23d. Date of d	lelivery Day	y Year
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€	g Phy er this neral d	e: To	27. Manner of Death	28a. Dat	te of injury	2 ER/Outpatie 28b. Time o		. Injury at		me 5 X . Residence 128d. Describe h		6 ☐ Other (Spe ry occurred	ecify)	
O	ath. or: Aft	ficat		stigation	onth, Day, Year	r) injury	м	work? 1 ☐ Yes 2	□ No					
Division of Vital Records,	or Att	Certificate:	3 ∐ Suicide 6 ⊡ Cou 4 ⊡ Homicide dete	rmined 28e. Place	ce of Injury - A ding, etc. (Spe	At home, farm, str ecify)	eet, factory, o	office		28f. Location (S City or Tow		nd Number or R	lural Rou	ite Number,
Ω	spitel hours nerel I	Medical	29a. Certifier 1 💢 Certifyi	ng Physician: To the	best of my kr	nowledge, death	occurred at th	ne time, date a	and place, ar	nd due to the ca	ause(s) a	and manner as	stated.	
	To the Hospitel or Attending Physicien: The lew within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	Med	only one) 3 ☐ Certifyi	I Examiner: On the bing Nurse Practition	asis of examin er: To the best	ation and/or inves t of my knowledge	, death occurr	ed at the time,	date and pla	the time, date a ce, and due to t	and place the cause	e, and due to the e(s) and manner	as state	s) and manner stated. d.
_	5 7 ₹ 7		29b. Signature and title of certif	ier /			1	icense numbe 1928	er			ate signed <i>(Mon</i> 21–2012	ith, Day,	Year)
	•		30. Name and address of person	un who completed as	Use of dooth /	(Itam 23s) /Time								
			Lila Bahadori, MC	0 - 10301 Ge	orgia Av	/enue, Sil	ver Spri	ing, Mary	yland 20	0902				
	Stat Registra	e ar	31. Date filed (Month, Day, Year, DEC 2 6 2	012 Sens	Registrar's Si	grature fact	2							

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Milton James Knight, Jr. 20 20 2012 2012 Dec. 6:40 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore ľo<u>wsor</u> 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Birthplace (State or Foreign Country) Months Days (Month, Day, Year) **Director** 214-24-5701 1X M 2 | F 83 April 13,1929 Maryland 10a, State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. isant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shoury or other traumatic event, the Medical Examples must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1915 Dundalk Avenue United States 21222 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: Completed 3 Widowed 4 Divorced White 1950 - 5115. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry cify only highest grade completed) Ruck Funeral Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years 3 Years Homes Mortician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Marie Morgan Milton James Knight, Sr. 19a. Informant's Name/Relationship (Type, Print) Elizabeth M. Knight (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from Stat Department Important: If any injury or once. 4 Donation Oak Lawn Cemetery 12/22/2012 Baltimore, Maryland 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 2122 21. Signature of ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ esophagea disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury Due to (or as a consequence of): To the Hospital or Attending Prysician; The Lett 1974-1975. Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 3 Probably 4 Unknown Completed 1 Yes 2 No Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WS NUR 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number ember 202012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IOTIV HARON JUHRUES 6701 31. Date filed (Month, Day, Year)
DEC 2 6 2012 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #19a Per FH G935 1/03/2013 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -AYTON Physician/ DOROTHY Day Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Future Care Nursing Home Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours Days Min (Month, Day, Year) Director 212-16-3530 1 M 2 F b2 25 98 14 MD Usual Residence of Decedent il Hygiene. I other than "naturel", or items 23e or 28a-f show vent, the Medical Exerciter result te i ciffied at 10a, State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2749 Riggs Ave 21216 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc ģ 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 V Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Worker Private 8th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith end Mental F 27 is marked of traumatic even Unknown pe permit. Page 1 and 2 should be Department of Health end Ment Important: If item 27 is marke any Injury or other traumatic Margaret Taylor 19A remarks Name/Relationship (Type, Print)
Alfred Laton-Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2749 Riggs Ave, Baltimore, Md 21216 Alfred Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/26/2012 Baltimore, Md Metro Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, 21215 Md Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive monie Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) If any leading to immediate cause. Enter Underlying Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy To the Hospital or Attending Physician: the within 24 hours after death.

To the Funeral Director. After this certificate I completely filled in by the funeral director, pag ibe C 1 Yes 2 🗌 No 1 Yes 2[Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **☑** No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Cath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ubelai MD 267 12 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) UBEROI 4410 ZA LI 31. Date filed (Month, Day, Year)

DEC 2 6 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar		State of	Maryiai	nd / Depa	artmer <i>tificat</i>			and M	ientai Hy	Giene Reg. No	20	2	4164	2
	Physicia	n/	1. Decedent's Name (First, N				•					2. Date of De Month	ath Da	ay Y	ear	3. Time of Death	
	Medic		David Hen 4a. Facility Name (if not instit	-	aWSON street and numb	er)		4b. City.	Town, or	Location		Decem		20 10 . County of	DIZ Death	010317	VI
	/	ψ.	Montgomery G	enera	1 Hospi	tal		01n						Montgo		У	
	Funeral		5. Social Security Number	6. Se			last birthday)	If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da		9	Birthpl Count	ace (State or Foreig	ηn
	Director		577-30-1005 Usual Residence of Decede		∑ M 2□F	8	5 Yrs.					Oct. 3	3, 1	927	Sout	h Carolin	ıa
	yland -f sho	ctor	10a. State 10b. Co	unty		10c. C	ity, Town or Lo	cation							10	Od. Inside City Limit	
	r 28e	Director	MD Pri 10e. Street and Number	nce G	eorge's	Mi	tchell	7 111e 10f. Zir	Code				10- 0	tinen of 18th	at Cause	1X Yes 2 N	40
	with the	Funeral	901 Kings V	allev	Drive				721				US.	itizen of Wh A	at Courn	ry?	
	death itams		11. Marital Status		12. Was Deced		.S. 13.	Was Dece	lent of His	spanic Ori	igin? (Spec	cify Yes or No-	_	14. Race -	America White, e		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other than "natural", or itams 23a or 28e-f show may highly or other traumatic evant, the MacTest Evandment must be notified at ODGe.	ted by	1 ☐ Never Married 2 🔀 3 ☐ Widowed 4 ☐ Divo		1 X Yes 2 If Yes, Give Year or Date	2□ No 19	47	I □ Yes				, , ,		Specify:			
15-(72 hou n "nat	Completed	(Specify only		ducation ide completed)		16a. Dece	kind of wo	rk done di	ition u <i>ring m</i> os	t of workin	ng .	16b. k	Kind of Busi	ness/Ind	ustry	
212	within giene. er tha		Elementary/Secondary (0- 12th	12)	College (1-4	or 5+)		o <i>notuse</i> Ll Se		28			Go	overn	nent		
pu	filed tal Hyg d oth evant,	To Be	17. Father's Name (First, Mid								er's Name	(First, Middle,	Maiden	Surname)			
<u> </u>	uld be d Men marke natic		Powell Laws		2:0		1				ia Ja						_
Σ	12 shoalth an alth an 27 is r traur		19a. Informant's Name/Rela June T. Law					-				Route Numbe				ode) D 20721	
ore,	of Hee		20a. Method of Disposition				Place of Dispo cemetery, crer	sition (Nar	ne of			ate		ocation - C			\exists
Ę	t. Page tment tent: I		4 Donation 5 Ot	ner (Specif)	y)		Vetera	ıns Ce	emete	ry	1/3/2	2013	Che]	Ltenha	m, l	Maryland	
Baj	permit Depar Impor eny In		21. Signature of Funeral Sen	ice Licens	etat	Bus	h) 22					. Jenki ad, Hya				ome, Inc. 20785	
			23a. Part 1. Enter the diseas shock, or heart failure.	e, or comp List only or	olications that ca ne cause on each	used the dea n line.	th. Do not ent	er the mod	e of dying	, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between	
- 1	hysician/ Medical	Ĥ	Immediate Cause (Final disease or condition resulting in death)	_	a (e) le	Fis										Onset and Death	
	Examiner			ſ	. Due to (or	as a consec	1967	ekie									
-	- ±	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J	Due to (or	as a consec		1411	,,,								
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8760	tificate ng phy as the		IF FEMALE:		u												
×	ith cert rittendir for use	by Physiclan/N	23b. Was decedent pregnant in the past 12 months?	104%		rth 2 🗆 Fe	tal death 3	Ectopic		,				23d. Date		ry Day Year	- 1
<u> </u>	he dea y the e	hysic	1 Yes 2 No 9 Unknown		9 Unkno	unt at time of wn	death 5L	Other (sp	еспу)					IVIOITI		ou, real	
9. O	that the plant the plant the detailer	by P	Part II. Other significant con	iditions co	ontributing to dea	ith but not re	sulting in the u	nderlying	cause give	en in Part	1.	23e. Did t	obacco (use contribu	ite to the	e cause of death?	
rds,	equires een sig nould b											10	Yes 2	□ No 3	☐ Prob	ably 4 🔀 Unknow	vn
eco	e has b gge 2 s	Completed										24a. Was auto perfo 1 Yes	psy	pric	r to con th?	sy findings available pletion of cause of	e
<u>a</u>	ian: It	Be C	25. Was case referred to med examiner?	lical			<u>-</u> .		26. Pla	ce of Dea	ith (Check		2. N	o) 1 L	Yes :	2 ∐ No	
Ĕ	hysic this ce al dire	욘	1 ☐ Yes 2 🖾 No		1		ER/Outpatier			4 LJ N	ursing Hon	ne 5 ☐ Resid	dence 6	5 ☐ Other (Specify)		
o uo	ath. r: After ne funer	Certificate:		ending vestigation	i i	injury Day, Year)	28b. Time of injury	м 2	8c. Injury work? 1 □ '			8d. Describe I	now injur	y occurred			
Division of Vital Records, P.O. Box 68	al or Atte s after de l Directo d in by th	Certif		ould not be etermined	28e. Place o	f Injury - At h ı, etc. <i>(Specii</i>	ome, farm, str fy)	eet, factory	, office		2	28f. Location (S City or Tov			or Rural i	Route Number,	
_	To the Hospital or Attending Physician: he law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director. Rage 2 should be detached for use a	Medical	(Check 2 <u>⊔</u> Med i	cal Exami	sician: To the bes ner: On the basis se Practitioner: 1	of examination	on and/or inves	tigation, in	my opinior	n, death or	ccurred at t	the time, date a	and place	e, and due to	the cau	se(s) and manner sta	ated.
	To the vithin To the complete	2	29b. Signature and title of ce	rtifier				290	. License	number	ite and plac		29d. Da	te signed (A	Nonth, D	ay, Year)	- 0
			Jocelejne						63							, 2012	
	5×		30. Name and address of per Jecelyne Kou					ntge	mer	4 Mc	dice	il Len	her	, Olr	iey	, Marylan	ne
	Stat Registra		31. Date filed (Month, Day, Ye	6 201	2 3. Reg	gistrar's Signa	. Lya	Red									

- Thursday, December 20,2012 10:02 AM Baltimore, Maryland 21215-0036 Lasser MaRUIN E LL エロー LaSS Division of Vital Records, P.O. Box 68760 10

	1	For State Registrar		State	of Ma	arylan	•	artmer ertificat			and N	/lental Hy	_	ne no.20	12	4	643
Physician Medica	_	1. Decedent's Name (F		•								2. Date of D Month 12	eath	Day 20	Year 2012	3. Time	e of Death
Examine		4a. Facility Name <i>(if n</i> o Suburban Hos		give street and nu	mber)				Town, or nesda	Location	of Death			4c. County Mantg			
Funeral Director		5. Social Security Num 110-18-0453 Usual Residence of D		6. Sex 1 X M 2 □ F	1	86 (In yrs. 1	ast birthday) Yrs.	If Unde Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, D 2-9-19	ay, Yea	r)	9. Birth Cou New	ntry)	te or Foreign
/aryland Be-f show tified at	ector		0b. County Montgo	mery			ry, Town or L	ocation									e City Limits
with the N 23a or 2 1st be no	Funeral Director	10e. Street and Number						10f. Zip						Citizen of V		intry?	
_ <u> </u>		11. Marital Status 1 □ Never Married 3 □ Widowed 4 □		12. Was Dec Armed F 1 X Yes If Yes, G Year or I	orces? 2 🗆 I ive	No 1	S. 13 944 to 946	Was Deced If Yes, spec	ify Cuba	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.))-		ck, White		,
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or treumatic event, the Medical Exam	Completed by		y only highes	's Education it grade completed College (al)		16a. Dec (Give life.	edent's Usu e kind of wo DO NOT use ef Scie	rk done d retired)	luring mos	st of work	ing		. Kind of Bo		•	5e
land 2 be filed w lental Hygi rked other iic event, 1	as I	17. Father's Name <i>(Fir</i> s Charles Lass					3112	0, 001		18. Moth		e (First, Middle itlebaum					
Mary 12 should alth and M 27 is mai		19a. Informant's Name Robert Lasse				•		•				al Route Numb Jashingto				Code)	
Baltimore, bermit. Page 1 and Department of Hea Important: If Item any injury or other		20a. Method of Dispos 1 🛴 Burial 2 🗌 4 🔲 Donation 5	Cremation		m State		Place of Disponentery, createry, cre	ematory or o	ther plac			Date 3-2012	1	Location -	•		•
Balti permit. I Departn Importa any inju		21. Signature of Funer	ral Service Li	censee Edwar	rd Sa	gel	2	22. Name ar 1170 Ro	d Addres	ss of Facili	ity Dar ke, Ro	nzansky-(ockville	Goldt	erg Me /land 2	emoria 20852	al Chap	oel
Physician/ Medical		23a. Part 1. Enter the shock, or heart for Immediate Cause (Fin disease or condition resulting in death)	ailure. List or	nly one cause on e	ach line ary <i>l</i>	Artery	th. Do not en		e of dyin	g, such as	cardiac o	or respiratory a	arrest,				mate Between nd Death
Examiner	ا <u>ق</u>	Sequentially list condi	ediate	b. ———			uence of):								\dashv		
be executed ician and burial-transit	al Examiner	cause. Enter Underlyicause (Disease or injuthat initiated events resulting in death) Las	ury		o (or as a	conseq	uence of):										
Ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be executed refath. Setor. After this certificate has been signed by the ettending physician and by the funeral director, page 2 should be detached for use es the burial-transi		IF FEMALE: 23b. Was decedent proint the past 12 mo 1 Yes 2 N 9 Unknown	nths?	d	e Birth gnant at	2 🗀 Feta	aldeath 3	☐ Ectopic ☐ Other (s _j		;y					te of deli	very Day	Year
ords, P.O. Box requires that the death been signed by the ette should be detached for	≥	Part II. Other significa	ant condition	ns contributing to	death bu	ut not res	sulting in the	underlying	cause giv	ven in Part	: I.			o use contr			of death?
fital Records, sician: The law required to entificate has been significate, page 2 should to the filtector, page 2 should to the filtector, page 2 should to the filtector, page 2 should to the filter to the filte	Completed											24a. Wa: auto per 1 Yes	opsy formed	? (death?	opsy finding ompletion of	gs available of cause of
Vital ysician:		25. Was case referred examiner? 1 ☐ Yes 2 💢 t		Hospital:] Inpatie	ent 2 🗶	ER/Outpati	ent 3 □ D	TOthe	er.		k only one) ome 5 ☐ Res	sidence	6 □ Othe	er (Specil	fy)	
Division of Vital To the Hospital or Attending Physician within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director		2 Accident	5 ☐ Pending Investig 6 ☐ Could n	ation	nth, Day	, Year)	28b. Time injury	м		yat ? Yes 2.⊑	□No	28d. Describe	how in	jury occum	ed		
Divisi		4 Homicide	determi	ned 28e. Plac build	ding, etc	. (Specify						28f. Location City or To	wn, Sta	ate)			umber,
he Hospital of the Funeral of the fu	Medical	(Check 2 L.	Medical Ex	Physician: To the caminer: On the bands Nurse Practitions	asis of ex	kaminatio	n and/or inve	stigation, in	my opinic	on, death o	occurred a	t the time, date	and pla	ice, and due	e to the ca	ause(s) and	I manner stat
To the within 2 To the comple		29b. Signature and title	e of certifier	~ Yu	a t	15		_		number	103	2		Date signed 21-2012		Day, Year))
		30. Name and address Gregory Kumk	kumian,						Beth	esda,	Maryl	and 20B1	7				
State Registra	-	31. Date filed (Month, I	Day, Year) 262			ır's Signa	ture										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onte Lee		1- For State Registrar		Department of Certificate of		d Mental Hy	Reg	2012	4 1 6 4 1
Physicia ledical Examin	44	1. Decedent's Name (First, Middle, Las MONTE T. L	EE				2. Date of Death Month December		3. Time of Death 2154 hrs
		4a. Facility Name (if not institution, giv Good Samaritan Hospital	e street and number)		4b. City, Town, or Baltimore	Location of Death		4c. County of Death	
Funeral Director		10.0 -	7. Age (In	yrs, last birthday)	If Under 1 Yea Months Day		8. Date of Birth	(MM/DDYYYY) 9. Bir Foreig Co	
ом апу		Usual Residence of Decedent 10a. State 10b. County		3ALTIMO					10d. Inside City Limits 1 VYes 2 No
ne Maryland or 282-f show fied at once.	Director	10e. Street and Number 6208 NORTH		IVE	10f. Zip Code	2.	100	g. Citizen of What Cour	ntry?
r death with th	L	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 Yes 2	er in U.S. 13. Wa	s Decedent of His	spanic Origin? (Sp n, Mexican, Puerto			can Indian, Black,
urs afte tural",	ᇫ	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5+)	ted) 16a. Deceden during m	ost of working life	tion (Give kind of w b. DO NOT use retire		16b. Kind of Business/I	ndustry
ID 21215-0036 should be filed within 72 hou and Mental Hygiene 77 is marked other than "na	Be Completed	17. Father's Name (First, Middle, Last)		LA	BORER	18.Mother's Name	•		CHOIL
and 2 should be filealth and Mental I fealth and Mental I fraumatic event,		19a. Informant's Name/Relationship (T BARBARA SUFTI		1 620	8 NOF	MHWOC	D DR.		10 21212
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify.	_	20b. Place of Dispos crematory or oth KING ME	ner place) MORIAL	PARK 12	129/12	20c. Location - City or BALTIME	DRE, MD
		21. Signature of Funeral Service Licen	MA MOIS	70 22.N VAI 49	lame and Addres UGHNU C. O5 YORK	s of Facility GREENE RD BA	FUNER LTO, MD	ALSERVICE CICIC	Approximate Interval
Physician /Medical Examiner				complicat					Between Onset and
•	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	<u> </u>			· · · · · /	
50, te be executed lysician and burial - transit	edica	X UNPENDED	AMENDED23a,2		er me,g9	35 1-10-1	.3 sm		
Box 6876(death certificate the attending phy ed for use as the E	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Fe	tal death 3 her (Specify)	Ectopic pregna	ncy	23d. Date of deliven Month	/ Day Year
i, P.O. Baires that the de signed by the ledetached f	2	Part II. Other significant conditions	contributing to death bu	at not resulting in the u	underlying cause	given in Part I.		pacco use contribute to	
of Vital Records, ag Physician: The law requirements the this certificate has been some all director, page 2 should be	Completed						24a. Was al autops perforn 1 Yes 2	y prior to o ned? death?	topsy findings available completion of cause of es 2 No
n of Vital ing Physician: After this certif	e le	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year)	2 ER/Outpatient	3 DOA	ary at Work?	g Home 5 F	Residence 6 Other	ubject was
Sion Attendi	ertification:	1 Natural 5 Pending 2 X Accident Investigati 3 Suicide 6 Could not determine	fd 12-17- 28e. Place of Injury	12 fd: 20: - At home, farm, stree Sidewalk	SUpm —	building, etc.	temperat 28f. Location (St	reet and Number or Ruate 5300 Blk.	intoxicated ral Route Number, City
e _ e e	Salc	29a. Certifier (Check only 1 Certifying Physic	ian: To the best of my kn r:On the basis of examina and manner stated.			late and place, and	due to the cause	(s) and manner as stat	
2 × ≥ € 8	Medi	29b. Signature and title of certifier	and marmer stated.		29c. Licens	se number M.E.		29d Date signed (Mo December 18, 20	
_		30. Name and address of person who Ana Rubio M.D., Ph. D.	Assistant Medical	Examiner 900	W. Baltimore	e Street, Baltin	nore, MD 212	223	
Sta Registr	1.7	31. Date filed (Month, Day, Year)	32. Registrar's S	Signatur	pho ?				

Physicia /Medic Examin	al		own, or Location of Death	Day Year 20 12 4c. County of Dea	th						
Funeral Director		215-02-6458 37 Yrs.	Year If Under 24 Hrs. Days Hours Min. 8. Date of (Month) 0 8 / 1	Balti (Birth (b, Day, Year) 9. Bir (1/1975 Man	thplace (State or Foreign ountry) Cyland						
ia-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore			10d. Inside City Limits 1X Yes 2 □ No						
23a or 26 ist be no	Funeral Director	10e. Street and Number 4150 Eierman Avenue 2120		10g. Citizen of What Co	ountry?						
er", or items 23a or 28a-f show Evaminer must be notified at	þ	11. Marital Status 1 □ Never Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decede If Yes, specification of the properties	nt of Hispanic Origin? (Specify Yes o fy Cuban, Mexican, Puerto Rican, etc.	r No-) 14. Race - Am Black, Whit Specify: B1	te, etc.						
event, the Medical Eval	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade 16a. Decedent's Usual (Give kind of work life. DO NOT use Cashier	Occupation done during most of working e retired)	16b. Kind of Business Restauran							
ic event	To Be (17. Father's Name (First, Middle, Last) Johnnie Scott	18. Mother's Name (First, Mic Mary A.Small								
traumat	-		Street and Number or Rural Route Norman Ave.Baltin								
Important: If item 27 is marked other than any injury or other traumatic event, Ite Inconce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name cemelery, crematory or othe Mt. Carmel Cer	e of Date ner place) Date metery 12/27/12	20c. Location - City or 2 Dundalk, M	Town, State						
any inj once.			Address of Facility Chatmar Belair Rd.Balti								
ician dical niner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due I. (or as a consequence of):	18	0	Approximate Interval Between Onset and Death						
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cheu for use as III	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (spe		23d. Date of de Month	elivery Day Year						
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certificate has beer ector, page 2 shou	Complete	Recalatrant esophageal candidiasis, R hypotensians, TPN, Serere C-diffi	afection 24a.	autopsy prior to death?	utopsy findings available completion of cause of s 2 No						
	To Be	25. Was case referred to medical examiner? Hospital: Other:									
Funeral Director: After this etely filled in by the funeral di	Certification: To	27. Manner of Death 1	ribe how injury occurred on (Street and Number or F Town, State)	Rural Route Number,							
To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 1 ertifying Physician: To the best of my knowledge, death occurred a 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, and due to in my opinion, death occurred at the t	the cause(s) and manner a ime, date and place, and du	as stated. re to the cause(s)						
	-	29b. Signature and title of certifier 29c.	License number	29d. Date signed (Mon	oth Day Vaar)						

DHMH 17 Rev 1/2001

Registrar

DEC 2 6 2012

parker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41646 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P^{M} Carrie Bel1 McClam 12 2012 7:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Thomas Moore Hyattsville George's Prince Social Security Number last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1936 1 □ M 2 🗓 F 76 Davs Hours May 20 Months Min. Director South Carolina 250-56-9310 Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland attracted to Heath and Mertal Hygiene. Arthent of Heath and Mertal Hygiene. ordant: If time Z7 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Prince George's Fairmount Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 59th Avenue 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 XMarried Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🛣 No Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Private 2yrs Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ira Graham Millie Skeeter permit. Page 1 and 2 should to Department of Health and Me Important; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis W. McClam/Husband 59th Avenue, Fairmount Heights, MD 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Benation 5 ☐ Other (Specify) 12/28/2012 Suitland, Maryland Cedar Hill Cemetery 21. Signature of Femeral Service Ligense 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequ ohysician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ugg ☐ Unknown detached is been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe certificate Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tyes 2 🗌 No Accident Investigation To the Hospital or Attency within 24 hours after death To the Funeral Director; 2 Accident
3 Suicide
4 Homicide completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of cortino

31. Date filed (Month, Day, Year)

Kurup

2 6 2012

Ajit

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835

Box 68760

P.O.

Records,

Division of Vital

University Blvd.

2. Registrar's Signature

29c. License number 36 8

Ste. 208 Hvattsville, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylar		artment tificate			Mental Hy	giene	2012	4	1647
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	uncate	or Dea	aur	2. Date of De	eath		3. Tin	ne of Death
	Physicia Medic		Carol Sue Malawer							Month 12	19	y Year 2012	5:4	5 рм
	Examin	er	4a. Facility Name (if not institution, of Casey House	give street and numb	per)		4b. City, To Rockvi		cation of Dea	th	1	. County of Dea ontgomery		
	Funeral			S. Sex	7. Age (In yrs. I	last birthday)	If Under 1		Under 24 Hrs				thplace (St	ate or Foreign
	Director		133–30–5279 Usual Residence of Decedent	1 □ M 2 □ X F	74	Yrs.	Month of a	,.	louis limit	4-12-1			rginia	
	land f show	tor	10a. State 10b. County		10c. Cit	ty, Town or Loc	ation		-					le City Limits
	e Mary r 28a- notifie	Director	MD Montgor 10e. Street and Number	nery	Poto	omac	T							Yes 2 No
	vith th	ral [12500 Park Potomac	Avenue			10f. Zip Ci 20854				0	izen of What Co ited Stat		
	items	Funeral	11. Marital Status	12. Was Deced			Vas Deceden	t of Hispa		Specify Yes or No-	_	14. Race - Ame	nican India	n,
36	after o	ρ	1 ☐ Never Married 2 ☐ Marrie 3 【X Widowed 4 ☐ Divorced	d 1 🗌 Yes If Yes, Give	2 🔀 No		Yes 2			to Rican, etc.)		Black, Whit		
9	hours natura ical E	lete	15. Decedent		es.		ent's Usual C					ind of Business	hite Industry	
218	nin 72 ne. than "r e Med	Completed	(Specify only highes: Elementary/Secondary (0-12)	grade completed) College (1-4	1 or 5+)	life. DO	O NOT use re	tired)	ng most of wo	orking	III			1
d 21	ed witl Hygier other t	BeC	17. Father's Name (First, Middle, La	4 st)		Fashio	on Consu			me (First, Middle,	1	tail		
/au	d be fill dental rrked c	၉	Herbert Berk					- 1	Jean Mez		, ivialueri :	Surnamej		
lary	should and M is ma auma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (S	treet and	Number or R	ural Route Numbe	er, City or	Town, State, Zi	o Code)	
e,	and 2 Health em 27 ther tr		Leslie Keenan - Dau 20a. Method of Disposition	ıghter	205.7				Road,	Rockville,				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp		State	Place of Dispos cemetery, crem san Memos	atory or othe	r place)	12-	Date 23-2012		ocation - City or ey, Maryl		e
Balt	permit. Departr Import. any inji		21. Signature of Funeral Service Lic	ensee Edward	d Sagel		Name and A		L_1	dward Sage Rockville,				
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that ca ly one cause on eac	used the deat h line.	th. Do not ente	r the mode o	f dying, sı	uch as cardia	c or respiratory a	rest,		Approx Interval	imate Between
1	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a		Leukemia	3						Onset a	and Death
	Examiner			Due to (o	r as a consequ	uence of):								
٠	d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (o	r as a conseq	uence of):								
	ate be executed physician and the burial-transit	Exan	that initiated events resulting in death) Last	c. Due to (o	r as a conseq	uence of):								
90	e be ey ysiciar ne burli	edical		d										
\sim	intificat ling ph	/Wec	IF FEMALE;	00- 16			•							
ŏ	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No	4 🗌 Pregna	irth 2 ☐ Feta ant at time of	al death 3	Ectopic pre				- 1	23d. Date of de Month	livery Day	Year
ш С	the de	hys	9 Unknown	9 🗌 Unkno		971								
o. O.	es tha signed I be de	þ	Part II. Other significant condition	s contributing to de	ath but not res	sulting in the u	nderlying cau	se given i	in Part I.			ise contribute to		
Sign	been should	Completed								24a. Was		24b. Were au		
ဋ္ဌ	sician: The law certificate has birector, page 2 s	dwo								auto perfe	psy ormed?	prior to death?	completion	of cause of
<u>a</u>	stan: T ertifica ector, p		25. Was case referred to medical examiner?					26. Place	of Death (Ch	1 \(\sum \) Yes eck only one)	2 K I No	o <u>l</u> 1∟⊥Ye	2 □ No	
₹	Physic this or ral dire	၉	1 ☐ Yes 2 🗶 No 27. Manner of Death			ER/Outpatien			4 Nursing	Home 5 ☐ Resi			ify) Hos	pice
o uo	ending sath. or: After the funer	Certificate:	1 X Natural 5 Pending 2 Accident Investiga	tion	, Day, Year)	28b. Time of injury	м 28с.	Injury at work? 1 Yes	2 □ No	28d. Describe I	how injury	y occurred		
Division of Vital Records, P.O. Box 68	al or Att		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place o	of Injury - At ho g, etc. (Specify	ome, farm, stre	et, factory, o	fice		28f. Location (City or To		d Number or Ru	rai Route N	lumber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifica completely filled in by the funeral director,	Medical	(Check 2 L Medical Ex	Physician: To the beaminer: On the basis lurse Practitioner:	of examination	n and/or investi	gation, in my	opinion, d	death occurred	at the time, date a	and place	and due to the	cause(s) and	d manner stated.
	with Total		29b. Signature and title of certifier	11198	CRN		29c. Li	cense nur i3201			29d. Dat	te signed (Mont	n, Day, Year)
	,		30. Name and address of person will	no completed cause		·	rint)	_						
			Debrah Miller, CRNI 31. Date filed (Month, Day, Year)		2000			ille,	Maryla	nd 20852				
	Stat Registra		DEC 2 6 2	012	surar s Signa	7. pa	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 15 2012 6:25 A M Sydelle Pearl Meiseles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Landow House Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Director 055-24-6991 1 🗆 M 2 🗶 F 2-28-1929 New York ure!", or items 23e or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits the Maryland Director MD Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 1799 East Jefferson Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 No 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Katz Louis Feiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14636 Pommel Drive, Rockville, Maryland 20850 Eileen Dykes - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12-19-2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel Brad Smetzer 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Ent. The disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myelodysplasia Medical Due to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use es the burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE f yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day is certificate has been signed by the director, page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 🕅 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Living Other: 4 Nursing Home 5 Residence 6 X Other (S ᅙ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death. I Director: After t 28c. Injury at 28d. Describe how injury occurred 1 K Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 24 hours Medical 29a Certifier within 24 hor To the Funel completely fi 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature nd title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D69568 12-17-2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geetha Chilakamarri, MD - 6121 Montrose Road, Rockville, Maryland 20852 31. Date filed (Month, Day, Year)

OEC 2 6 2012 2. Registrar's Signature

CHMH 17 Rev 06-2011

State Registrar

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. 2 Pay 20**1**2 12:30 A M Mules Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southerly Court Apt. 508 Baltimore Towson Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 220-22-7608 1X M 2 | F 83 August 5 1929 Maryland Usual Residence of Decedent ul Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 No Towson Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 U.S.A. 1 Southerly Court Apt. 508 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Forces Black, White, etc. <u>۾</u> 1 Never Married 2 X Married 1 X Yes 2 □ No Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Food Distribution CEO Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I æ Ethel Manager Gilbert C. Mules 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1 Southerly Court Apt. 508, Towson, Maryland 21286 Kathryn Mules / Wife Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State DulaneyValleyMemorialGdns 12/27/2012 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Functal Separce Licen 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Bal 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hours after death.

uneral Director: After this certificate has sly filled in by the funeral director, page 2. autopsy performe 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\overline{\text{M}}\) Residence 6 \(\sum \) Other (Specify) 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 2 Accident 1 Yes 2 🗌 No Investigation 3 D Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar use of death (Item 23a) (Type, Print)

ess of person who completed ca

lled (Month, Day, Year)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Richard Edward Noonan December 2012 1:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7100 Martell Avenue Dundalk Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Min 02-07-1932 215-30-5654 **Director** 1**X** M 2 □ F 80 Maryland Usual Residence of Decedent 28a-f shov 10a, State 10b. County or than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2 No Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 7100 Martell Avenue 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 white 1 🗆 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) Plumber Plumbing 1 permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Noonan Rosie Lawiski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Rhodes (Nephew) 257 New Bridge Rd. Rising Sun, Maryland 21911 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Sacred Ht. of Jesus 12-28-2012 4 ☐ Donation 5 ☐ Other (Specify) Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ teriosc lenotic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician is the burial Physician/Medical Box 68760 use as attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 Records, Completed been si 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has page 2 autopsy performed? 1 Yes 2 No prior to completion of cause of death? this certificate 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 work? 1 Yes 2 No To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ocember 21

Registrar
DHMH 17 Rev 06-2011

State

and address of

2 6 201

31. Date filed (Month, Day, Year)

DEC

23a) (Type, Print)

of death (Item

Baltimore, Maryland 21215-0036

for State Registrar

Physician/ Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Hebrew Home

. Social Security Number

215-76-7692

Usual Residence of Decedent

Helen Nicopoulos

4a. Facility Name (if not institution, give street and number)

6. Sex

1 🗆 M 2 🔀 F

	rland f show d at	tor	10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
	Mary 28a-i	irec	Maryland Montgor	nery	Darne						1 ☐ Yes 2 🗓 No
	e filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	Autumn Ian		10f. Zip Code				tizen of What Co	•
	ems 2	une	13424 Scottish 11. Marital Status	12. Was Decedent		20878 13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec	ify Yes or No-		ited Sta	
9	ter de , or it	by F	1 Never Married 2 Marrie		No	If Yes, specify Cuba		ican, etc.)		Black, White	e, etc.
003	urs af tural" al Exe	ted	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.							nite
15-	72 ho n "na Medic	Completed	15. Decedent' (Specify only highest	grade completed)		. Decedent's Usual Occup (Give kind of work done life, DO NOT use retired)	during most of working	g	16b. K	ind of Business	Industry
212	led within I Hygiene. other tha		Elementary/Seconday (0-12) 12	College (1-4 or s		omemaker			Own	n Home	
pu	υ≥€t	To Be	17. Father's Name (First, Middle, Las	•			18. Mother's Name	(First, Middle,	Maiden :	Surname)	
ryla	should be file h and Mental H 7 is marked o raumatic eve	_	Louis Perdikar				Lucy Fus				
Ma	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship George J. Nicop			o. Mailing Address (Street 0827 B 2nd S					
e,	of Health of Health if item 27 r other tra		20a. Method of Disposition			f Disposition (Name of ry, crematory or other pla awn		ber 29,	r	ocation - City or	
imo	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		Parki Memor	ry crematory or other pla awn ial Park	Decem 20	ber 29, 12	Ro	ckville	, Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Hea Important: If item any injury or other once.		21. Signature of Julieval Service Up	Nsee C	M01619	22. Name and Addre	Pumphrey	Funera	1 Ho	me, Rocl	kville, Inc.
			23a. Part 1. Enter the disease, or o	omplications that caused	d the death. Do					KVIIIE,	Maryland 20850 Approximate
	Physician/		shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each line Advana	1 -	ementia					Interval Between Onset and Death
ميسدد	Medical Examiner		resulting in death)	_ d	a consequence						
	Examine	er	Sequentially list conditions,	b. — — —		-0.					
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequence	or):					
	execution and ial-train	Еха	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):					· · · · ·
90	te be nysicia he bur	dica		d							
687	auth certificate be executed attending physician and for use as the burial-transit	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					004 Data at 4a	
Box 68760	g e g	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth	2 Fetal deat at time of death	h 3 Ectopic pregnan 5 Other (specify)	су			23d. Date of del Month	Day Year
P.O.	The law requires that the deater has been signed by the apage 2 should be detached		Part II. Other significant condition	s contributing to death b	out not resulting	in the underlying cause g	iven in Part I.	23e. Did to	obacco u	use contribute to	the cause of death?
S, F	uires t n sign Ild be	Completed by						1 🗆	Yes 2	₩ No 3□P	robably 4 🗌 Unknown
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Rec	The law cate has I page 2 s	Som						perfo	rmed?	death?	s 2 🗆 No
	cian: sertific sector,	Be	25. Was case referred to medical examiner?	Hospital:		26. P	lace of Death (Check	only one)			
fΝ	Physi this c	٠. ت	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 _ Inpati		utpatient 3 DOA Time of 28c. Injur	4 Nursing Hon	ne 5 Resid			ify)
o u	nding tth. : After s fune	cate	1 2 Natural 5 Pending 2 Accident Investiga	(Month, Da	y, Year)	injury wor	k? Yes 2 \Begin{align*} No \Begin{align*} 2 \Begin{align*} 2 \Begin{align*} No \Begin{align*} 2 align	sa. Describe r	iow injury	y occurred	
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	Certificate:	3 Suicide 6 Could no 4 Homicide determin	t be		urm, street, factory, office	2	8f. Location (S City or Tou			ral Route Number,
Ω	spital hours neral d filled	Medical				death occured at the time					
	the Ho	Med				or investigation, in my opini ledge, death occurred at the					cause(s) and manner stated stated.
	To T		29b. Signature and title of certifier Mina Jack			Doc 6				te signed (Month	
	MM		30. Name and address of person when Mina Fazli, Mi		leath (Item 23a)	(Type, Print)	icville Mi	D 20	85.2		
	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 6 20		and Olementons	barks					
DHI	MH 17 Rev 7/20		DEO 2 0 ELO	No.	7- 77						
					0	RIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Months

Yrs.

7. Age (In yrs. last birthday)

75

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Rockville

Reg. No. 2012

4c. County of Death

Montgomery

December 20, 2012

2. Date of Death

8. Date of Birth
(Month, Day, Year)
June 5, 1937

41651

1:30 P M

Greece

Birthplace (State or Foreign Country)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month John Roger Nelson 20 December 2012 1:50 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15205 Gravenhurst Terrace North Potomac Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 579-16-7108 **Director** 1 🗓 M 2 🗆 F 92 Jan. 30, 1920 Washington, D.C. Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 28a-f Maryland | Montgomery 1 Yes 2 No North Potomac 10e. Street and Number ō 10a, Citizen of What Country? must be Funeral 23a 15205 Gravenhurst Terrace 20878 United States within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner rmed Forces?

XYes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1939–69 1 Yes 2 X No "natural", Completed 3 X Widowed 4 Divorced Specify: White the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Hygier other t Chief Petty Officer U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 1 and 2 should be find Health and Mental item 27 is marked John Otis Nelson Mary Patricia Goddard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Guerra / Daughter 15205 Gravenhurst Terrace, North Potomac, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Montgomery crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State December 24, 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 2012 Bethesda, Maryland 21. Sign ture Fundra Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non Hodgkins Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Das to for as a consequence of, Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify 2 🛚 No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director, After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending injury 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

State Registrar 29b. Signature and title of certifit

31. Date filed (Month, Day, Year)

Geoffrey Coleman, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D37142

1355 Piccard Drive, Rockville, Maryland 20850

29d. Date signed (Month. Day, Year)

December 20, 2012

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 2. Date of Death 3. Time of Death Physician/ Rattnowich 8:00 A M DECEMBER 2012 Medical 4a. Facility Name (f not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3615 FORDS LANE, BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Director 524-69-6902 1 M 2 XF 93 10/22/1919 UKRAINE Usual Residence of Decedent permit. Pege 1 and 2 should be filed within 72 hours effer death with the Marylend Depertment of Heelth and Mental Hygiene. Important: If then 27 is merked other then "neturel", or Items 23e or 28e-f show eny injury or other treumetic event, the Medical Examinat Franchist. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3615 FORDS LANE, #204 21215 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN ပ္ LEYBOVICH DAVID MONYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONID RABINOVICH/SON 346 CHAMBORLEY DRIVE, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM 12/24/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE. 23a. Part 1. Enter the disease propinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physicien: The lew requires that the deeth certificate be executed ettending physicien and for use es the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant. 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 months Day signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an autopsy performed? 1 Yes 2 No Be B 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 200 မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner at Leath Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No After To the Hospital or Attending within 24 hours after death.

To the Funerel Director: After the Funerel Directors of the funerel Directors of the funerel Directors. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MK

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE AUGSBURG LUTHERAN HOME LOCHEARN Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months 1 M 2 X F 7/18/1913 213-44-8998 Yrs. MARYLAND 99 Director Usual Residence of Decedent 28a-f shov 10b. County notified at 10a. State 10c. City. Town or Location 10d, Inside City Limits Director MD BALTIMORE LOCHEARN 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be a Funeral 6811 CAMPFIELD ROAD #103 21207 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) should be file and Mental F is marked of ပ FRED KRAUS LENA KIRNER other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or Attack JOHN F. RUTHKE/SON 1905 REDWOOD AVENUE PARKVILLE, MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date DULEANEY TO VALUEY OF MEM. 1XXBurial 2 Cremation 3 Removal from State 12/27/2012 COCKEYSVILLE, MD 4 ☐ Dogration 5 ☐ Other (Spegffy) **GARDENS** Signature of Funeral Service Licensee 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P.A. MO1139 TOWSON, MD 8521 LOCH RAVEN BLVD. 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre shock, or heart failure. List only one clause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ THEROSCLERATIO disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and -tran Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? **Director:** After this certificate of in by the funeral director, page 2 N Yes 25. Was case referred to medical 26. Place of Death Check only one) Be examiner? Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manufer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ☐ Natural ☐ Accident 5 Pending work 2 🗌 No hours after death Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier сопріете (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State

wi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Date filed (Month, Day, Year)

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Box

DUINCES MILL MAZILLA

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Examine		4a. Facility Name (if								Location			40	c. County of D		
/		Carroll								mini				Carr		
Funeral Director		5. Social Security No. 213–34–7		6. Sex 1 🔀 M	2 🗆 F	7. Age (In yrs. 95	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	ay, Year)		Count	lace (State or Foreign ry) 'VDCUS
T 00 4	. 1	Usual Residence of 10a. State	Decedent 10b, County			10- 0	. T								1.0	Od. Inside City Limits
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	MD	ĺ	roll		100.01	ty, Town or L Tane	ytowi	า						'	1 Yes 2 No
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Medical		resulting in death)	16	a	Due to (o	r as a consec	uence of):	ELE	7 10 11		710	TIVITY			+	
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ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): PERITO NITIS														
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To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria	Completed by Physician/Medical			L d	DUC	DENA	L PE	RFOR	A77	ON	-				_	
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ath ce	ian	23b. Was decedent in the past 12	months?		1 🔲 Live B	irth 2 Fet ant at time of	al death 3	☐ Ectopic ☐ Other (s _t		У				23d. Date of Month		ry Day Ye <i>a</i> r
the a)sic	1 ☐ Yes 2 ☐ 9 ☐ Unknown			Unkno		death 5	Other (a)								
that the	<u>~</u>	Part II. Other signif	icant conditi	ons contrib	uting to de	ath but not re	sulti <i>n</i> g in the	underlying	cause giv	en in Part	l.	23e. Did	tobacco	use contribute	to th	e cause of death?
quires en sigi suld be	ed L	PATIENT	WAS	Foun	D TO	HAVE	LARGE	GALL	STONE	- (6X	3 cm	1 🗆	Yes 2	! ☑ No 3 ☐	Prob	ably 4 🗌 Unknown
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Attender deat ctor:	Ĕ∣	2 Accident 3 Suicide	6 Could		8e. Place o	of Injury - At h	ome, farm, st			163 2 _	-	28f. Location (Street ar	nd Number or	Rural	Route Number,
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the h	Me	only one) 3	Certifying	Nurse Pra				death occu	rred at the	e time, d <i>a</i> te		e, and due to the	ne cause	(s) and manner	as sta	ated.
5 ½ 6 8		29b. Signature and	title of certifie	#	H.	O .		290		number				ate signed (Mo		
LMA		30. Name and addr	ess of nerson	who compl			m 23a) (Tyne	Print)	2 /2	238 €	,		/	2/16/22	5 (_
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Registra	10		EC 26	4012	J. C.	un p	1	62								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 19a, 20c per fh g934 12-26-12 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 Physician/ RIVES WILLIAM.H. 8:00AM 2012 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTO HUE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. (Month, Day, Year) Director 1 Ø M 2 □ F 8 B Yrs. 124 VA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Macked Examiner must be notified at once. 10c, City, Town or Location 10d. Inside City Limits Director SAltimore 1 Yes 2 No MI 10f. Zip Code 2/2/5 10e. Street and Number 10g. Citizen of What Country? Funeral 11514 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No δ Baltimore, Maryland 21215-0036 Specify: AFRICANAMERICAN If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. De NOT use retired (Specify only highest grade completed) RAPHIC Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rives 19a. Informant's Name/Relationship (Type, Print) Rural Route Number, City or Town, State, Zip Code) 20a. Methyod of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date William cemetery, crematory or other place) 1 2 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the drease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MYOCARDIAL Physician/ INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year 4 Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Congestive heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 🗌 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Shalim. B 12/21/2012 -D65616 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 22 Avenue MD-21215 W. Belvedre 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RUSSELL Physician/ Month 12 IMOAN Day 19 10.000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5220 tonk Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 214-30-7234 Director 1 □ M 2 🗹 F -15-1934 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥Yes 2 ☐ No imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 5220 oad 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) hools choo Be 17. Father's Name (First, Middle, Last) Brunson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/009 19a. Informant's Name/Relationship (Type, Print) Abincolon, MI) heresa aughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) remation 12-27-2012 Yanover, MD 21. Signature Fineral Service Liensee 22. Name and Address of Facility Varshn Breene Funeral Services NO 155. 4905 more 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio vascul on diseas Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a cor ad by the attending physician and detached for use as the buriai-transit or Attending Physician: The law raquires that the death certificate be axecuted Briait Canan Due to (or as a consequence of): resulting in death) Last Physician/Medical CO 10 Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death NIA 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signad t d ba det 23e. Did tobacco use contribute to the cause of death? ξ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this cartificate has been si ral director, page 2 ehouid 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Ves 2 No : After this cartifica a funeral director, p 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? ↓ 1 ☐ Yes 2 ☐ No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deat 1 P Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending within 24 hours aftar death.

To the Funarai Director: A compiately filled in by tha fi Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MA 40490 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) baltmon MIOSUAS 12AIKER 5010 York Rd 21212 31. Date filed (Month Day Year) -32. State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 19, 2012 10:40 AM Dorothy Elizabeth Rider 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville 12 Vashi Lane Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Months Davs Hours 579-07-5638 1 □ M 2 🗓 F Yes Oct. 26, 1915 97 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Vashi Lane 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Payroll Clerk County Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin Luther Price Florence Elizabeth Flynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia S. Rider/Daughter 12 Vashi Lane, Rockville, Maryland 20852 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State December 27. 1 Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2012 Rockville, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Funeral Home, Rockville, Inc. Rockville, Maryland 20850 M01173 Fordery 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease disease or condition resulting in death) Due to (or as a consequence of) Hypertension Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Cause (Disease or injury Chronic Renal Failure that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Anemia 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner?

1 X Yes Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be Box 68760 <u>Ф</u> Division of Vital Records, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag

Physician/

Medical

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examiner must be notified at

Physician/

Examiner

Medical

Examiner

Physician/Medical

Be Completed by

Medical Certificate: To

29a. Certifier

29b. Signature, and title of certifier

31. Date filed (Month, Day Year) 12

Baltimore, Maryland 21215-0036

JOW

State Registrar

1396 Piccard Drive, Rockville, Maryland Irina Bobrova-Sherman, M.D. 32. Registrar's Signature

Suerman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0052832

29d. Date signed (Month. Day. Year)

December 24, 2012

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Donna Lynn Snowden Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 216 84 3035 1 🗆 M 2 🔀 F 50 Sept.9,1962 Maryland 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1655 Riverwood Rd. 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Š filed within 72 hours efter of Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled N/A Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Stanley Snowden Nancy Sunderland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna S. Snowden (Sister) 1655 Riverwood Rd. Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pege 1
Depertment of I
Importent: If it
eny injury or of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Garden's 12/24/2012 Baltimore, Maryland 21. Signature of Funeral Service License ^{22. Name and Address of Facility} Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex ohm Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ END STAGE RENAL DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Cause (Disease or i Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospitel or Attending Physicien: The lew requires thet the death certificete be each fours effer death. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 👿 No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Records, P.O. To the Hospitel or Attending Physicien: The lew requires that: within 24 hours either death. To the Eurerel Director: After this certificete has been signed to completely filled in by the funeral director, page 2 should be detenmined. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) မ 1 ☐ Yes 2 👿 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation 6 Could not be 1 🗌 Yes 2 🗌 No Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 🗶 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and Affic 6 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed vause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Registrar's Signatu State Registrar

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CEMBER

DONNA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 221 Amelia Emma Saboy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 591 rase HOSPita Sedale imore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Hours (Month, Day, Year) Director 1 M 2 F 215 34 0804 10/17/1934 78 Maryland Usual Residence of Decede or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 1000 Franklin Avenue 21221 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. ğ 1 Never Married 2 XMarried 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. d other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Education Custodian permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the once. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Therese Bova Joseph Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Emma Feehely (sister 8617 Heathermill Road Nottingham Maryland 21236 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem Gardens 12/27/2012 Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA of Funeral Sep 1407 Old Eastern Avenue Essex Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fail Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and use as the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician thed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, I 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) |은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore

DHMH 17 Rev 06-2011

State Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARIE STEWART 201 Medical 4a. Facility Name (if not institution, give street and number)
(IN VECS ITY OF MARY LAND MEDICAL CENTER) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours None Director 1 □ M 2 🖾 F Dec. 19, 2012 Maryland 12 27 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Modical Examinar must be nothing at 10d. Inside City Limits 10b County 10c. City, Town or Location Directo Maryland Anne Arundel Edgewater 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4035 Chesapeake Drive 21037 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 X Never Married 2 Married ☐ Yes 2 🖾 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes. Give Specify: 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bryan J. Stewart, Sr. Stephanie Hartwick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Hartwick / Mother 4035 Chesapeake Dr., Edgewater, Maryland 21037 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of P
Importent: If Ite Dec 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Metro Crematory, Inc. 2012Catonsville, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility Irkley-Ruddick Funeral Home, P.A. I Crain Hwy., S.E., Glen Burnie, Ē MD 21061 23a. Part 1. Futer the Part 1. Furter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEVERE RESPIRATORY FAILURE disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) PRE MATURI 1222 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a conseduence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the bunal-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 No o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SPECTED SERSIS Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည No Yes 2 ☐ No No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 12 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. \$ignature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 29c.per DVR.g934 12-26-12 sm. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Albert Henry Samuels 1:40 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cross Holy Hospita Silver SPring Mont gomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 527-44-1031 Hours Director 1 X M 2 □ F 81 122 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Forest Hills Lucens 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118-17 Union 11375 UCHPIKE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or 3 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 Divorced Specify Specify: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, Ihe Magnosi. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Aerospace 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Samuels Frankenthal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuels 118-17 Union Turnpike, Forest Hills, NY 11375 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State New Montefiore Cem. 12/23/2012 Pinelawn, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sol Levinson & Bros. Inc. 8900 Reisterstown Road, Pikesville, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MULTI-ORGAN FAILURE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and burlal-transit or Attending Physician: The law requires that the death certificate be executed RENAL FAILURE Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burla Physiclan/Medical PANCYTOPENIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day 9 Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires th within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 ☐ Yes 2 💢 No 1 Minpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number LMOWICE C 12/23/2012 D66372 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJID RAHMANIAN SHAHRI, M.D., 1500 FOREST GLEN RD, SILVER SPRING, MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19b, per fh, g934 12-26-12 sm State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4:34 SACHS 19 201 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month. Day, Year) Director 216-26-7390 1 □XM 2 □ F 07/18/1938 MD 74 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland ortent: If Item 27 is marked other then "naturel", or items 23e or 28e-f sho injury or other treumatic event, <u>the Medical Examiner must be notified at</u> Director 1 Yes 2 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 8516 MEADOWSWEET ROAD 21208 USA 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by and 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give WHITE 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 5+ ATTORNEY LAW Be pelij 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Importent: If Item 27 Is marked c ၉ NADICH NATHAN SACHS FANNIE Maryl t and Number or Rural Route Number, City or Town, State, Zip Code)
11 Rd. Baltimore, MD,21210
SWEET ROAD, PIKESVILLE, MD 212 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street 6 Hamlet Hi 3516 MEADOW 6 Hai MARJORIE GOODMAN/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) BALTIMORE HEBREW CEM 12/21/2012 REISTERSTOWN, MD 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 ROAD. PIKESVILLE Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart railwe. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate onuce. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The lew requires that the death certificate be executed the ettending physician end thed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 9 Unknown څ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MOM 2 A No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No Director: After this certificate within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Nonpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11021204 (death (tern 23a) (Type, Print) Towson 31. Date filed (Month, Par, Year) 32 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death t's Name (First, Middle, Last) 2. Date of Death Physician/ DMent an Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE PIKESVILLE COURTLAND GARDENS If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 220-52-6621 Director Yrs 09/23/1913 idence of Decedent MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3505 PHILIPS DRIVE 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Yes. Give Specify 3 Nidowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) OWNER MORTON SCHENK & CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ္ GRESSER ROSE t. Page 1 and 2 should be rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICTOR SCHENK/SON 3505 PHILIPS DRIVE, PIKESVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH TFILOH CONGR. 12/23/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line.

Immediate Cause (Fibal disease or condition resulting in death) 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Approximate Interval Between Onset and Death Physician/ Medical resulting in death) ²Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 🗌 Yes 2 1 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 \(\text{\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exitit{\$\tex{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$ prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes မှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Mannes of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 19 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prnysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

SKY APAM MD DOSTUBS 29d. Date signed (Month, Day, Year)
12/20/12
who completed cause of death (Item, 23a) (Type, Print)
-AMD 2135 SMIMAY BAITMON MO 21209

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JEAN L. SINGER DECEMBER 22. 2012 5:55 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS NURSING HOME TIMONIUM BALTIMORE 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 11/21/1921 Country)
WEST VIRGINIA Days Hours Min Director 91 235-20-7150 1 M 2 X F ire!", or items 23e or 28a-f show Examirer must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE PHOENIX 1 Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14013 FOX LAND ROAD 21131 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "naturei", or à 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN MERTZ EDNA STRANDGAARD and A 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT C. SINGER/SON 14013 FOX LAND RD. PHOENIX, MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H injury or 12 Burial 2 Cremation 3 Removal from State DUEANEY COVALLEY MEN. 12/26/2012 COCKEYSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MOO2 17 22. Name and Address of Facility JOHNSON-FOSBRINK FUNERAL HOME, P.A. TOWSON. 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physicien and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ erei Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

Ves 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 No Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funerei C completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie R04358D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Justine Preis, CRNP 2300 Dulaney Valley Road, Timonium, MD 21093

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Singer

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lbert Fletcher St	1 F	- For State Certific	nent of cate of		id Mental I		Reg. No	2012	41666
Physiciar Medical Examin	n/	1. Decedent's Name (First, Middle, Last) Albert Fletcher Stewart Sr.				2. Date of De Month Decemb	Day	Year 2012	3. Time of Death 1312 hrs
)		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or			4	c. County of Death	
Europol		4061 Saint Johns Lane 5. Social Security Number	irthday)	Ellicott City		Irs. 8. Date of I		Howard I/DD/YYYY) 9. Birtl	nplace (State or
Funeral Director		214-46-1290 ₁ × _M ₂ _F 65	Yrs.	Months Day		lin. 08/0		O 4 7 Foreign	Maryland
yne		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Locati	on					10d. Inside City Limits
E .	٥		cott	City			10 0	1100	1 Yes 2 X No
eath with the Maryland items 23a nr 28a-f sho	E	10e. Street and Number 4061 Saint Johns Lane		10f. Zip Code 21 042			USA	tizen of What Cour	ury ?
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s nr 28s-f she traumatic event, the Medical Examiner must be notified at mee	Funeral	11. Marital Status 1 Never Married 2 Married 2 Armed Forces? 1 Yes 2 X No		s Decedent of Hi es, specify Cuba			No-	14. Race - Americ White, etc.	
s after d	≥ -	3 X Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No		of work done	16b	Specify: Bla	
72 hours	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	ost of working life	e. DO NOT use r				
15-0036 filed within 7 Hygiene. d other than, the Medica	Completed	12th grade Po	osta.	l Worke		me (First, Middle		S.Post	Office
21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natura e event, the Medical Examira	Š B	Kenneth William Stewart Sr.			Mary E	eletche	er		
D 2121 should be fi and Mental 7 is marked natic event,	卢	19a. Informant's Name/Relationship (Type, Print) (Son) Albert Fletcher Stewart Jr						City or Town, State	
e, MD I and 2 sho Health and item 27 is	-	20a. Method of Disposition 20b. Place	e of Disposi	ition (Name of ce	emetery,	Date	20c	. Location - City or	Town, State
L ~ 4 2 2 1	1	4 Donation 5 Other Specify: King	Memo	orial I			-	ndsor M	
Baltimo permit. Page Department o Important: injury or nth		2) Smature of Funeral Service I censee							eral Home MD.21215
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.							Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascul Due to (or as a consequence of):	lar Disea	ase					Death
		Sequentially list conditions, b							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
nted nd ransit	Exa	events resulting in death) Last Due to (or as a consequence of): d				_			
lox 68760, eath certificate be executed a attending physician and for use as the burial - transit	edical	UNPENDED AMENDED							
876(rtificate ing phy		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth	₂ Fe	etal death 3	Ectopic pre-	gnancy		3d. Date of delivery Month [y Day Year
Box 6876. e death certificate the attending phy ed for use as the b	Physician/M	4 Pregnant at time of death 1 Yes 2 No 9 Unknown Unknown	5 Ot	her (Specify)					
ires that the de signed by the	by Ph	Part II. Other significant conditions contributing to death but not result	ting in the u	underlying cause	given in Part I.				the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the raper death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	eted t	Liver disease				24a. W	as an	24b. Were au	topsy findings available
ecords, ne law requirate has been sige 2 should	Completed					au pe 1 ✓ Ye	topsy rformed s 2		·
tal Rection: The certificate ector, page	Be	25. Was case referred to medical examiner? Hospital: Inpution 2 FR			ce of Death (Che		7	dence 6 🗸 Othe	
of Vil ing Physic After this	의	1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28	VOutpatient Bb. Time of I		jury at Work?	rsing Home 5		njury occurred	. Scerie
tendingleath.	ation	1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year)			Yes 2 No		(0)		I D. J. Markey City
Divis tal or A rs after al Direc	Certification:	3 Suicide 6 Could not be determined (Specify)	i, farm, stre	et, factory, office	building, etc.		n (Street n, State)	and Number of Ru	ral Route Number, City
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t		29a Certifier 1 Certifylng Physician: To the best of my knowledge,	death occu	rred at the time,	date and place,	and due to the c	ause(s)	and manner as stat	ed ne cause(s)
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/o and manner stated. 29b. Signature and title of certifier	Ji ilivestiga		nse number			d. Date signed (Mo	
		Carol Hallan		0.0	C.M.E.		De	ecember 20, 2	012
I dut		30. Name and address of person who completed cause of death (Item 23: Carol H. Allan, MD Assistant Medical Examiner		Baltimore St	reet, Baltimo	ore, MD 2122	23		
	ate	31. Date filed (Month, Day, Year) 2. Registrar's Signature							
Regist	rar	DEC 2 6 2012 June 1.	bark	-			_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mertine Elizabeth Shelton 7:50P M Medical 12 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilcrest Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 220/18/3841 1 D M 2 1 F 86 Yrs. 11/02/1926 Virginia ga 1 and 2 should ba filed within 72 hours after death with the Maryland it of Health and Mentel Hyglane.

If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 1316 Highland Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ð 1X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry est grade completed) (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Private Domestic 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Ernest Freeman Queen Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Davis/Daughter 1316 Highland Drive Baltimore,MD.21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Paga 1:
Dapartmant of I
Important: if it
any injury or of
once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet.Cemetery Owings Mills,MD 21. Signature of Funeral Service Liger/see 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore, MD. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) auexealic Physician/ Medical Due to (or as a consequence of): Examiner gw Car cumoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The lew requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 **Division of Vital** 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 횬 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1/1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nyrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number D72139 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Steel Suit 4105 Baltimore MD 21204 ABBAS 6701 Q. 31. Date filed (Month, Day, Year) State 37. Registrar's Signature DEC 2 6 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:35 PM Robert Swearinger Dec. 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months Days Director 578-88-5560 1 XM 2 F 52 April 27,1960 Washington, DC Usual Residence of Deceder r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **IISA** 500 Chillum Road, #101 20783 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 X Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Roofer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed treet of Health and Mental H rtant: If item 27 is marked ot jury or other traumatic ever Oneil Swearinger Lillie Cartledge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other to once. Lillie Swearinger/Mother 500 Chillum Road #101, Hyattsville, MD 20783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Mem. Cemetery: 12/27/2012 Hyattsville, Maryland Signature of Funeral Service Licensee. 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ cellula ancer - Advanced epa 0 disease or condition Medical resulting in death) Examiner ito Sequentially list conditions, Examine Due to (or as a consequence or if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 24 hours after death.

9 Funeral Director: After this certificate has been signed by the atter ietely filled in by the funeral director, page 2 should be detached for 1 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 D668026 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) アメカ M 名 ゴイ

State Registrar

DHMH 17 Rev 06-2011

MD

AVENUE

32. Registrar's Signature

CARROLL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 0630 AM 2012 CIEORGE SILCS JR BROOKS 21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Harford Havre de Grace 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yei Days 1932 Maryland 1**X** M 2 □ F Months Hours **Director** 80 215-32-2643 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M. dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Harford Aberdeen 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 1533 Perryman Road 21001 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married ģ Yes 2 No Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 9 Plumber Plumbina Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Brooks Sills, Sr. Martha Rebecca Ayres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Patricia Sills / Wife 1533 Perryman Road, Aberdeen, Maryland 21001 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Rose Hill Svcs, LLC 11-23-2012 | Bel Air, Maryland 21. Signatur of Funeral Service Licen 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final SPIRATION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner YSPHACIA Sequentially list conditions ll any leading to immedicause. Enter Underlying Cause (Disease or iinjury death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year ed by the a 9 Unknown Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖟 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this α completed filled in by the funeral dir this 27. Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier 11/21 2012 rson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

500 Upper Chesapeake Dr., Bel Air, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:30 A M Kathleen Lucille Barnes Stevens 19. December 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 352 Ahern Drive Harford Edgewood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Director 202-14-5865 1 M 2 XF Nov. 13, 1922 Pennsylvania 90 "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Edgewood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21040 USA 301 Laburnum Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Mamed 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Church Organist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Margaret (unk) Conway Frank (unk) Showman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Renehan / Daughter 301 Laburnum Road, Edgewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Lutheran 12/24/2012 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee McComas Funeral Home, P.A. 22. Name and Address of Facility essea Stillava 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death signed by the at Id be detached for Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 Թ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate It in by the funeral director, pag 2 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Caregiver 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 47809 12/29/2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Phone Steerdeen 16 Heerdeen 4 wow ree

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10:35 A M Louis Smith 12 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Rockville Nursing Home Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Director 173-12-9967 1 **X** M 2 □ F 94 Yrs 5-17-191B PA ed other then "neturel", or items 23e or 28a-f show event, the Medical Examinar must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 □ No Montagmery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20906 15320 Pine Orchard Drive 1 end 2 should be filed within 72 hours efter death of Heelth and Mental Hyglene. i feen 27 is merked other then "neturel", or items other traumetic event, the Medical Examinar ma Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married WII Maryland 21215-0036 1 Yes 2 X No Specify: 3 Nidowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Car Salesman Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Ada Davidson William Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Jasmine Drive, Rockville, Maryland 20853 Beverly Alexander - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ₹ permit. Pege 1 Department of Important: If if eny injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 12-18-2012 Olney, Maryland 21. Signature of Fugeral Service Licensee Brian Deibler 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Brain Tumour Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed to hours after death. ate has been signed by the ettending physicien end page 2 should be deteched for use es the burial-tren that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 K Unknown 24b. Were autopsy findings available 24a, Was an certificate has autopsy performed? 1 Yes 2 X No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No erei Director: After this certifica filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 2X No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural injury work? 1 🗆 Yes 2 🗆 No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospitel within 24 hours a To the Funerel Completely filled Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOW 12-17-2012 00047330 Woluus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas V. Joseph, MD - 50 W. Edmonston Drive, #207, Rockville, Maryland 20852 31. Date filed (Month, Day, DEC 2 6 32. Registrar's Sign State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 8:30 PM December 18. 2012 Ziad Halim Shehadeh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Director 443-44-9893 1 X M 2 □ F Yrs January 20 1938 Palestine Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🛛 No Derwood Marvland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20855 United States 7701 Goodfellow Way 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married ۵ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) International Development Elementary/Secondary (0-12) College (1-4 or 5+) 5+Consultant in Aquaculture Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Nadeemeh Yacob Halim Shehadeh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 20855 7701 Goodfellow Way, Derwood, Shehadeh/ Wife Maha Z. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 21, cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State orium, Inc. : 2012 | Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300West Montgomery Avenue
Rockville, Maryland 20850-2805 4 Donation 5 Other (Specify) Signature of Fune al Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death addiopulmon Immediate Cause (Final arrest Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit burial-transit una that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 21 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) **Division of Vital** 25. Was case referred to medical Be Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{ Residence } 6 \subseteq \text{ Other (Specify)} 2 No Inpatient 2 ER/Outpatient 3 DOA 1 Yes 잍 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rocky. He, hd 20850 medical Car Yeniqalla 9901 Ilshak MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Ronald Solesby December 2012 3:05 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8 Date of Birth Funeral 7. Age (In yrs. last birthday) (Month, Day, Year) Hours Min Months 219-34-8426 Director 1 1 M 2 □ F 75 Nov. 13, 1937 North Carolina Usual Residence of Decedent shov and 2 should be filed within 72 hours after death with the Maryland Flealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? Funeral 20851 406 Calvin Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Completed by Yes 2 ☐ No Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Divorced Year or Dates 1955-1959 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Heating Conditioning Elementary/Secondary (0-12) College (1-4 or 5+) Steam Fitter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Lewis Solesby Mary Beatrice Ard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie B. Solesby/Wife 406 Calvin Lane, Rockville, Maryland 20851 item 2 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or oth Date Montgomery crematory or other place) December 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Crematorium, Inc. 21. Signatur of Funeral Sovice Licensee .22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Bladder Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or i that initiated events and Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use es the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No ☐ Yes 2 🖾 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \boxtimes$ Other (Specify) \bigcirc Hospice 1 Yes 2 🖾 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 To the l 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) re and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) R143201 12.19.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

Debrah Miller, CRNP

31. Date filed (Month, Day, Year)

Road, Rockville, Maryland

6001 Muncaster Mill

32. Registrar's Signature

12-09660 Renee Tripp Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Renee Tripp	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. 2012 4167
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 4.005 here
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Cente Baltimore 4c. County of Death MA
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
	Usual Residence of Decedent
land f show any once.	MA Baltane
the Maryland 3a or 28a-f sh otified at onc	
her death with the Maryland ", or items 23a or 28a-f sho er must be notified at once / Funeral Director	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at nonce TO Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medican To Be Comple	
MD 2121 d 2 should be fit this and Mental I are 27 is marked an a 77 is marked To Be	19a. Informant's Name/Relationship (Type, Print) (Rorgy anna Edmands - Mother 12) Shannon Drive Balto, nd. 21213
ages 1 and 2 s ant of Health a	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State
Baltimore, ME permit. Pages I and 2 si Department of Health at Important: If item 27 injury or other traum	1 Sonation 5 Other Specify: 21 Signature of Funeral Service Licenses Allely M. Clallace Department of Funeral Service D
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.
ted d ansit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
50, ic be executed ysician and burial - transit	□ AMENDED 23a,27,per me,g935 1-23-13 sm
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Es	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Ectopic pregnancy 23d. Date of delivery Month Day Year
P.O. Bost that the degree by the detached for by the by the by the by the by the by Phy	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach entification: To Be Completed by P	24a. Was an autopsy findings available autopsy findings available prior to completion of cause of performed? death?
Vital Rec ysician: The l his certificate I director, page	25. Was case reterred to medical 26. Place of Death (Check only one)
F Vital Physician: To Be	1 Ves 2 No 1 inpatient 2 Ver exocupation 3 DOA 4 Notising notice 3 Content.
ion of tending Pl eath for: After the funera	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred
Division of To the Hospital or Attending Puvitin 24 hours after death To the Funeral Director: After to completely filled in by the funeral Hospital Certification: Tedical Certification: T	2 See. Place of Injury - At home, farm, street, factory, office building, etc. 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hosp within 24 hos To the Fune completely fi	
To with To con	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 20, 2012
	30. Name and address of person who completed cause of clear (Item 23a)
State	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature
Registra	DEC 2 6 2012 Person A. Sarki

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical Month 1407 A M December 2017 TOPOROVSKY RIMA 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Balhmore Baltimore Sinal Hospoita 01 N/A Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** TOPOROVSK Days Hours (Month, Day, Year) Director 216-29-6924 1 □ M 2 🗓 F 06/01/1932 AZERBAIJAN 80 Usual Residence of Deceder 27 is marked other then "netural", or items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at 10d. Inside City Limits 10h Count 10c. City, Town or Location 72 hours after death with the Maryland Director 1 🗆 Yes 2 😾 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA APT. 1 AMLEHT COURT. #1D 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, RimA 11. Marital Status Black, White, etc. 1 Never Married 2XXXMarried ģ 1 ☐ Yes 2 ♣ No Specify: permit. Page 1 and 2 should be filed within 72 hours afti.
Department of Health end Mental Hygiene.
Importent: If item 27 is marked other then "netural", item in jury or other treumetic event, the Medical Examone. Specify: WHITE 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Knowna College (1-4 or 5+) Flementary/Secondary (0-12) **5**+ **TEACHER** EDUCATION Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ KARASIK BORIS DRUTMAN LEAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 AMLEHT COURT, APT. #1D, BALTIMORE, MD BANTON TOPOROVSKY/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM: 12/24/2012 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Live see 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Michael 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Directo for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burlet-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Year Month Day 1 Yes 2 9 Unknown 2 🗌 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cosonasi Mellitus Meale 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Tes **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) , MBBS ahullehin December 83,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL GOKHROO MBBS SINAI 31. Date filed (Month, Day, Year) State 26 racke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 8:40PM December May K. Troy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Under 1 Year Montgomery Manor Care Potomac

5. Social Security Number 6. Sex Birthplace (State or Foreign Country) If Under 24 Hrs. Date of Birth 7. Age (In yrs, last birthday) Funeral Min. (Month, Day, Year) Months Days Hours 106-38-9042 Director 1 □ M 2 🗓 F 1924 June 16, China 88 Usual Residence of Deceden 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
The marked other then "natural", or items 23a or 28a-f show other traumetic event. The Medical Feature. 27 is marked other then "natural", or items 23a or 28a-f show traumetic event, the Modical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 Yes 2 No Montgomery Rockville Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20852 United States 12111 Putnam Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Nidowed 4 Divorced Asian Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 6 Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gee Chan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3110 Russell Road, Alexandria, Virginia 22305 Eva T. Cooper/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 e
Department of H
Importent: If ite
eny Injury or ott December 21, 2012 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland Parklawn MemorialP<u>ark</u> 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service License M00335 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cerebrovascular Accident Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a nonsequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) been signed by the a should be detached g Unknown g 🔲 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2: autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗓 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d, Describe how injury occurred 1 🕅 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar romat

2 6 2012

Thomas Masterson,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Sigrature

D50534

6801 Whittier Avenue #205, McLean, Virginia 22101

December 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rene Month 12 incom Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Heartlands Assisted Living Severna Park Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) 081-01-9837 **Director** 1 M 2 Yrs. 98 Usual Residence of Decedent 10 1914 New York or 28e-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ent: if Item 27 is marked other than "natural", or Items 23a or 28e-f sho ed other than "natural", or items 23a or 28e-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 555 Crestpark Drive 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Typist Zinc Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edward John Miller Emma (nmn) Jahries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita C. Bittner / Daughter 26536 Outrigger Cove, Millsboro, DE 19966 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I importent: If its eny injury or of once, once, once, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 12-27-12 Baltimore, Maryland Name and Address of Facility
Name and Address of Facility
Comas Funeral
Home, P.A.
W Broadway, Bel Air, Maryland 21014

Ag Signature of Funeral Service ima 50 W. Broadway, 23a. Part 1. Ent. (the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he of failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Beath Physician/ STAGE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, If any, leading to minimadiate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence or), ii or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 Tyes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Yes 2 000 1 Inpatient 2 ER/Outpatient 3 DOA Assisted Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Living 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 39: Name and address of person who completed cause of death (Hem 23a) (Tipe, Print)

DHMH 17 Rev 06-2011

State Registrar NEUIT

31. Date filed (Month, Day, Year)

A

12-09702 Ric

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible

cky Williams			rtment of Health and Mental H		2012 4167
		Registrar	tificate of Death		g. No.
Physici edical Exami		Kicky Williams		2. Date of Death Month December	
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore	1	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lat \$\frac{10}{2}\lightarrow 86.58 12 \text{F} 47	st birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min Yrs.	_	n(MM/DD/YYYY) 9. 8irthplace (State or Foreign 1965 Roughty) And
any	ľ	Usual Residence of Decedent	Fown or Location	,	10d. Inside City Limits
Maryland 28a-f show d at once.	ctor	10a Street and Number	Himore 10f. Zip Code	10	1 Xyes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once	al Director	833 W. PRAH Sticet Apt 506 11. Marital Status 12. Was Decedent Ever in U.S.	21201		USA
death or ite	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, 8lack, White, etc. Affician American
ours aff tural'	d by	or Dates:	16a. Decedent's Usual Occupation (Give kind of v		16b. Kind of Business/Industry
036 thin 72 hone. than "na tedical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti	red)	Disabled
21215-0036 unld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Cor	17. Father's Name (First, Middle, Last) KEII4 WilliAms	18.Mothers Name TheIm		aiden Surname)
MD 21; rd 2 should thith and Men m 27 is mar	Το	19a Inform nt's Name/Relationship (Type, Print) Thelma Williams	19b. Mailing Address (Street and Number or F	Rural Route Numb	per, City or Town, State, Zip Code)
S 2 E E E		20a. Method of Disposition 20b. Pi	833 W. PRAH Street - ace of Disposition (Name of cemetery, ematory or other place)	Date	20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: Uiter injury or other to		4 Donation 5 Other Specify: 21 Signature of Funeral Service Ligensee	M+, ZION DEC. 22. Name and Address of Facility Nancy M. Wallace Fu	reral S	LAUSdowne, Md. ervice miore Manufand 21229
Physician		23 Part For the disease, or complications that caused the death. I	Do not enter the mode of dving, such as cardiac of	et -BA(+	it, shock, or heart Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	er	,	8etween Onset and Death
	19	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
e executed cian and rial - transit		d. X UNPENDED AMENDED23a,pt.II	,27,per me,g938 4-19-1	3 sm	
760, cate be physici he buri	Med	IF FEMALE: 23c. If yes, outcome of pregna	ancy		23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3 Ectopic pregna	incy	Month Day Year
s, P.O. Bc			ulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
S, P.O.	ed by	Cocaine Use		1 Yes	
Records, The law require	Completed			24a Was ar autops perform	prior to completion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical	26.Place of Death (Check of	1 ✓ Yes 2	
Vita ysicini his cer directo	o Be	examiner?	Othor		esidence 6 Other
n of Niding Ph.	-1		28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred
Division of Vital pital or Attending Physician: ours after death. reral Director: After this certifiled in by the funeral director	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At hom	ne, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rural Route Number, City ite)
To the Hospital within 24 hours: To the Funeral completely filled	edical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge			
To the within To the comple	Medi	one) 2 Medical Examiner: On the basis of examination and and manner stated. 29pSignature and title of certifier	29c License number		29d Date signed (Month, Day, Year)
		Church	O.C.M.E.		December 21, 2012
			^{3a)} 900 W. Baltimore Street, Baltimore,	MD 21223	
Sta ∉Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature 11. Date filed (Month, Day, Year)	Sales		

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. dent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14 Right Aileron Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours 007 32 9459 75 Director 1 □ M 2 1 F 03/12/1937 Maine 28a-f shov th and Mental Hygiene. 27 Is marked other than "natural", or Items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State the Maryland 10c. City. Town or Location 10d. Inside City Limits Direct Maryland Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 Right Aileron 21220 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) of Health and Mental of Health and Mental fitem 27 Is marked rother traumatic ev 2 Wibut Foster Lane Alma Delvina Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David F. White (son) Perryville, Maryland 21903 100 Cove Point Way 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or otl once. Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc 12/22/2012 | Baltimore, Maryland 21. Si ture of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock or heart faile Immediate Cause (Final END-Stage Physician/ disease or condition resulting in death) Medical Due to (or as a consequipe e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 6 Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tes 2 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 ______ Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Self-trying righting in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier nskajapatne MD DOOS 7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smin NS (Cajapa Ksemp 7.835 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 21 2012 2:22 AM BERNARD WEISMAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days (Month, Day, Year, Hours Min. 212-50-5861 Director 1 X M 2 - F 65 09/06/1947 MD permit. Pege 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentai Hyglene. Importent: if item 27 is merked other then "neture!", or items 23e or 28e-f shoven injury or other treumetic event, the Madical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 7215 VERBENA ROAD 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☒ No If Yes, Give 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PHARMACIST Pege 1 end 2 shouid be flied with nent of Health and Mentai Hygler ent: If Itam 27 is merked other t PHARMACOLOGY Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည TSAAC WEISMAN MARY COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARILYN WEISMAN/WIFE VERBENA ROAD, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) EL MEMORIAL PARK! 12/23/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Ligaçõe 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final HYPOXIA Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ORUNARY ARTERY DISEASE hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or Injury that initiated events resulting in death) Last The lew requires that tha deeth certificete be executed the ettending physician end ched for use es the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) been signed by the should be datached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?
1 Yes 2 No After this certificate 1 Yes 2 No To tha Hospitei or Attanding Physician: 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work?
1 Yes 2 No i Diractor: A 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) MD 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVAN ENG 6701 DWSON 31. Date filed (Month, Day, Year, 37. Registrar's Signature Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SYLVIA Physician/ D. WILSON 12 Month 19 Day 2012 Year :42 FM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNION MEMORIAL HOSPITAL . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) **Director** 218-60-3636 1 ☐ M 2 🛣 F 57 MAR 31 1955 MD Usual Residence of Decedent Paga 1 and 2 should ba filad within 72 hours aftar daath with the Maryland mant of Haalth and Mantal Hygiana. "ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f ahov 28a-fahov in and Mantal Hygiana. ?7 is marked other than "natural", or Items 23a or 28a-f aho traumatic event, the Medical Evaminar must be natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director NA BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6001 PARK HEIGHTS AVE. APT. 3B 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2/1/2/No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify SpecifyBLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) llth ASSEMBLY WORKER PUBLISHING CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 MELVIN JOHNSON, SR. MARGARET WISE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3414 ASSOCIATED WAY, OWINGS MILLS, MARGARET JOHNSON - MOTHER MD21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Paga 1 a
Dapartmant of IImportant: If Ite
any Injury or ott Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/29/2012 ARBUTUS, MD ARBUTUS MEMORIAL 21. Signature of Edneral Service Lic MARCH Address of Facility T 4300 WABASH AVE, BALTIMORE, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician 4 day Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attanding Physician: The law requires that the death cartificate be executed signad by tha attanding physician and d ba datachad for usa as tha burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? aftar daath. **Director:** After this certificata has baan sig d in by tha funaral director, paga 2 should I 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident М Investigation 3 Suicide 6 Could not be fillad in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined To the Hospital within 24 hours a To the Funaral C completaly filled Medical 29a. Certifie Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar DHMH 17 Rev 06-2011

State

only one)

29b. Signature and title of certifie

KAKKAN 31. Date filed (Month, Day, Year)

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alle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NION ME

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41682 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 2:11 AM Wells Sr. Jacob DRC Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death N nell Hospital Baltimore Baltimore CITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Month, Day, Year) **Director** 251-60-1371 81 10 06 31 SC Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4504 Groveland Ave 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates chown Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) New Penn Motor 12th grade life. DO NOT use retired) College (1-4 or 5+) Tractor Trailor Driver Express Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Friendly Wells Mary Richardson Patient alth and N 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 siment of Health a Mamie Wells-Wife 4504 Groveland Ave, Baltimore, Md 21215 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a, Method of Disposition 1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Donation 5 Other (Specify) Woodlawn 21. Signature of Funeral Service Licens 12/28/2012 Woodlawn, Md 22. Name and Address of Facility
March F/H West 0 4300 Wabash Ave, Baltimore, Md 23a. Pail 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Complications disease or condition resulting in death) of Renal Failure Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician a Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 2 🗆 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) D59062 20 M.D. December 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Belvedere Ave, Baltimore MD 21215 2401 Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician/ 10:45 Eleanor Williams 2012 December 18 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Landover Hillview Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days (Month, Day, Year) Months 219-20-9399 89 Baltimore, 1 □ M 2 ₺ F **Director** Feb 6 1923 Maryland Usual Residence of Dece ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Director 1 X Yes 2 No Md Prince George's Landover 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with USA 20785 8309 Hillview Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 0. 1 Yes 22
If Yes, Give
Year or Dates 1 Never Married 2 Married Completed by 2X No Baltimore, Maryland 21215-0036 Black. 1 ☐ Yes 2X☐ No Specify: "natural", 3 Widowed 4 Divorced al Hygiene. Jother than "natura vent, the Medical E 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Private Nurses Aide vrs traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked oft any injury or other traumatic even once. ည Flournoy Janie Watkins William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8309 Hillview Road Landover, Maryland 20785 Renee Thomas/Dgt. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) 12/27/2012 Clinton, Maryland Resurrection Ceme. J. B. Jenkins Funeral Home, Inc. 22. Name and Address of Facility 21. Signature, of Funeral Service Licensee 7474 Landover Road Hyattsville, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria /Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ed by the a detached f 1 Yes 2 5 9 Unknown Yes 2 X No Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 X Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has page 2 Director: After this certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\overline{\mathbb{X}}\) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural 5 Pending hours after death. Accident Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 aren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McCormick Drive, #180 Largo, MD 20774 Maren Mayhew 1801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2012 DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Janice Wikes 2012 8:00 DM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Arcola Nursing Home Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) Director 166-26-8473 1 M 2 K F 80 Yrs 7-12-1932 Pennsylvania Usual Residence of Deceden show 10a, State 10b. County ral", or items 23a or 28a-f sho Examinar must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera United States 20906 3702 Marble Arch Way Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify. 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk Retail Jewelry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file Ith and Mental H 27 is marked of traumatic ever မ Charlotte Lottman permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic (Samuel Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 147 West 94th Street, #2, New York, New York 10025 Michael Wikes - Son timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🔲 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 12-24-2012 Adelphi, Maryland 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel 21. Signature of Funeral Service Licenses Brad Smetzer Brully 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Cardio Respiratory Arrest Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Month I or Attending Physician: The law requires that the dear after death.

Director: After this certificate has been signed by the a d in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕮 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗓 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D56691 12-23-2012 30. Name and a fdr ss of person who completed cause of death (It 3a) (Type, Print) Chousia Sultana, MO - 12107 Heritage Park Circle, Silver Spring, Maryland 20906

Registrar

State

31. Date filed (Month, Day, Year) **DEC 2** 6

32 Registrar's Signatu

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		1 - For State Registrar		tato o	i wa yiari	•	tificate			.1101 141	ontai i i	Reg. No	00	112	4	685	
		Decedent's Name (First, Middle	e, Last)								2. Date of D	eath Da	<u>ک</u> ـــ	Year	3. Time o	f Death	
Physicia /Medic		Marian,	Wr:	2050	ek						OLLEM	ber	5 A M				
Examin	er	4a. Facility Name (If not institution				_			Location of	Death		4c. County of Death					
		Johns Hopkins Bay 5. Social Security Number	/VIEW I	viedic	7. Age (In yrs. I		Balti If Unde		If Under 2	24 Hrs.	8. Date of Bi	rth		or Foreign			
Funeral Director		219-26-5202	1 🗆 M	2 🛛 F	75	Yrs.	Months	Days	Hours	Min.	(Month, D		937	Ma	$rac{rv1}{rv1}$		
D *		Usual Residence of Decedent 10a. State 10b. County			10c Cit	y, Town or Lo	cation				4				10d. Inside 0	City Limits	
Maryla f sho ed at	lor	MD N/	΄ Δ		100. 01	y, 101111 01 Ec	Journal	Ralt	imore	e Cit	·v					s 2∐No	
death with the Maryland ms 23a or 28a-f show must be notified at	Director	10e. Street and Number					10f. Zip					10g. Cit	tizen of \	What Cou	intry?		
th with	ralD	934 South Cur	ley S	tree	t				21224	ŀ		United States					
tems er mu	Funeral	11. Marital Status		Armed Fo		S. 13.	ispanic Orig n, Mexican,	in? (Spe Puerto l	cify Yes or Ne Rican, etc.)		14. Rac	ce - American Indian, ack, White, etc.					
hours after tural", or ite	by F	1 Never Married 2 Marı 3 Widowed 4 Divorced		1 ☐ Yes If Yes, Giv Year or Da	e		1 🗌 Yes	2 K No	Specify:				Specify:				
2 hou atural cal Ex		15. Deceder	nt's Educati	on			dent's Usu			and a complete		16b. Kind of Business/Industry					
within 72 ene. than "nat	Completed	(Specify only highe Elementary/Secondary (0-12)		College (1	-4 or 5+)	life.	DO NOT u	se retired)	during most)	OI WUIKI	ng		-		d Transit tration		
filed wi Hygien other th ent, the		12 Years 17. Father's Name (First, Middle,	/ acti			Se	ecreta	ary	18 Mothe	r'e Name	(First Midd				ation		
d be fi	Be (Chester A.	,	sek	1						M. Ro	(le, Maiden Surname) quska					
2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me	2	19a. Informant's Name/Relations						s (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparatment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Mr. Albert Wrz	osek	(Bro	ther)	2621	. Lynl	orook	Road	l Di	ındalk						
of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐ Remo	oval from		Place of Disp cemetery, cre			e)		ate	20c. L	ocation	- City or	Town, State		
t. Pag tment tant: jury		4 Donation 5 Other (S	pecify)		S						1/2012	Bal	ltim	ore,	Maryl.	and	
permi Depar Impor any ir		21. Signature of Funeral Service	Sub	ohnn	y Gibbs	D	uda-R	luck		al H	ome of						
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complicati	ons that o	aused the deat	h. Do not en	ter the mo	Wise de of dyin	Ave.	_Dun cardiac	da1k。 or respiratory	Mary arrest,	lanc	1 21	Approxima		
Physician		Immediate Cause (Final	only one ca	ause on e	ach line.	12									Onset and		
/Medical	Je.	disease or condition resulting in death)	a	Due to	(or as a conseq				1						0 1	, , , , ,	
Examiner		Sequentially list conditions,	b	10	ulmona		Er	260	105						L da	75	
ed isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury															
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rtificat ng phy e as th	Med	IF FEMALE:															
leath certifi attending I d for use as	ian/	23b. Was decedent pregnant in the past 12 months?		1 Live	tcome of pregna birth 2 - Feta	al déath 3	_ Ectopic		y			23d. Date of delivery Month Day				Year	
the a	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☑ Unknown		9 Unkr	nant at time of d nown	leath 5	Other (s	pecny)				-			_		
The law requires that the death certificate be the has been signed by the attending physicia page 2 should be detached for use as the bu	by PI	Part II. Other significant conditi	ons contrib	uting to d	leath but not res	sulting in the	underlying	cause gi	ven in Part	1.	23e. Dio	d tobacco	use co	ntribute to	the cause of	death?	
quires in sign											1	Yes	2 🗌 No	3 🗌 Pr	obably 4	rUnknown	
law requas been 3 2 shou	Completed											opsy	24b	prior to	itopsy finding completion of		
sician: The la certificate has irector, page 2											1 🗌 Yes	-	lo	death?	2 🗆 No		
Physician: this certifica	Be (25. Was case referred to medica examiner? 1 ☐ Yes 2 No		pital:	Inpatient 2	ER/Outpatie	nt 3□D	OA Oth	er.		n <i>(Check only</i> me 5 □ Re		6 7 01	thor (Sno	2ift/)		
ing Phys T. After this funeral d	n: To	27. Manner of Death		28a. Date	of Injury	28b. Time	of	28c. Injur Worl	y at		28d. Describ				sny)		
auth. rr: Afte	atio	1 Natural 5 Pendii 2 Accident invest	gation	(IVIOII	th, Day Year)	Injury	М		Yes 2 🗌 I	No							
or Atter de lirecte in by t	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern			e of injury - At he ing, etc. <i>(Specif</i>		reet, factor	y, office				on (Street and Number or Rural Route Number, Town, State)					
To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After the completely filled in by the funeral Director.		29a. Certifier 1 Certifyi	ng Physici	an: To the	best of my kno	owledge, dea	th occurred	at the tir	me, date an	id place,	and due to the	ne cause	(s) and r	manner as	s stated.		
e Hos	edical	(check only 2 Medica one)	Examiner		pasis of examina oner stated.	ation and/or i	nvestigatio	n, i n my c	opinion, dea	ath occur	red at the tim	ne, date a	nd place	e, and du	e to the cause	∋(S)	
To th	Ž	29b. Signature and title of certific	er				29	0	e number						h, Day, Year)		
		12	1	~	2	<u> </u>		UC	200	0		De	cen	1 65	192	012	
IOV		30. Name and address of person	Lan.	12-	Merc		,		40	40 F	astern A	\ven:	le. R	altime	ore, MD	21224	
Sta	ate	31. Date filed (Month, Day, Year)	- 21	32. F	Registrar's Sign	ature	N.J						, .		,	,	
Registi		DEC % 6 5	UIZ	Dens	m p.	you											

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2ď**ľ**2 7:10 December Ronald Craig Wehrle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6 Sex Funeral Days (Month, Day, Year) 214-50-8326 Director 1 XM 2 □ F Apr 17. 1948 Ohio permit. Pege 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show they injury or other treumatic event, the Michol Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 1 Yes 2 No <u>Bal</u>timore Pikesville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 21202 205 Sherwood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 XYes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced white Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Owner HVAC Company Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie Carroll Hitchcock Eugene Elmer Wehrle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Sarah Woods Drive; Red Lion, PA 17356 Jason R. Wehrle son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cremation 3 Removal from State 1 Burial 2 Towson, MD 4 Donation Other (Specify) Hilltop Service Corp. 12/26/2012 21. Signature of Funera Service Licenses 1050 York Road 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one tasks on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Amyohreshic Lateral Medical Due to (or as respective of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last or Attending Physicien: The law requires thet the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an certificate Yes 2 D 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar Or the basic of examination and/or invariant and the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier

24 hours To the I

> Miller Box 1525 Owings Mille 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tayound Miller MD

29b. Signature and title of certifier

Registrar

State

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

747683

21117

29d. Date signed (Month, Day, Year)

12/23/12

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 4168/ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Barbara White 6:58 Рм E. December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10 Nobility Court # J Baltimore Owings Mills 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours Min. 211**-**28-6948 Director 1 🗆 M 2 🛛 F 75 April 1, 1937 Pennsylvania Usual Residence of Decede er than "natural", or items 23a or 28a-f show the Medical Examiner rupst be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖄 No **Baltimore** Owings Mills MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 USA 10 Nobility Court #J 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene, item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Harms William White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Kathleen O'Brien/ Religious Assoc. 305 Cable St. Baltimore, MD. 21210 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite eny injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 DO Other (Specify) 12-28-12 Ilchester, MD. Ilchester Cemetery Ruck Towson Funeral Home, 21. Signature of Funer 22. Name and Address of Facility 1050 York Rd. Towson, MD. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ scale Medical resulting in death) Examiner 15 YEARS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to for as a consequence of Exami To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the human toward. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month 9 Unknown Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 30. Name and add s of person who completed cause of death (Item 23a) (Type, Print) ROBERT

CHMH 17 Fev 06-2011

State

Registrar

TUMBA

82. Registrar's Signature

31. Date filed (Month, Day, Year)

DEC 2 6 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12, 2012 2:30 a Mary Kay Rhoades Atwell December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Union Hospital of Cecil County Cecil E1 kton 215°68 4704 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral Director** 1 🗆 M 2 🗶 F 55 Nov. 13,1957 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Cecil Port Deposit 1 ☐ Yes 2 🕅 No 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 3 Garden Drive 21904 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married "natural", or p 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) V.A.Maryland HealthCare System Perry Point, Maryland and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Records Nine Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumation once. ൧ Francis Rhoades Grace Virginia Emory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Paul Atwell (husband) 3 Garden Drive, Port Deposit, Maryland 21904 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State West^{ery}Notternghall^{sce)} Cemetery 12/17/12 Colora, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate artery disease Onset and Death Immediate Cause (Final Phi i i n disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to for as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-trans Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death should be detached the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 N certificate 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 X No ြု Notice 1 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of After t 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 24 hours after deat Funeral Director: filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiners On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Plactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 6

Registrar DHMH 17 Rev 06-2011 only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

16USTINE

32. Registrar's Signature

29c. License number

D0062190

SHAHNAWAZ KHAN MD

HERMAN HWY, SUITEA, CHESAPEAKECITY, MD21915

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 20°12 9:30 Ам Ernest Lindsav Allston Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Talbot Easton Talbot Hospice 6. Sex 1 M 2 D F Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min July 13. Maryland Director 220-32-1610 78 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10c, City, Town or Location Director 1 ¥ Yes 2 □ No Marvland | Caroline Denton 10e. Street and Number 10f. Zip Code ö 10g, Citizen of What Country? iral", or items 23a or Examiner must be i Funeral USA 21629 110 South 8th Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural" Completed 3 Divorced 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Stocker Food Retail 12 H.S. Grad. of and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H is marked ot 2 Maha1a Allston, Jr. Arthur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Denton, MD 110 South 8th Street Nancy Cobble/P.R. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otf Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Denton Cemetery 12/4/2012 Denton, MD 21. Sig / ure / Funeral Service Lie Moore Funeral Home, P.A. 22. Name and Address of Facility 12 South 2nd Street Denton, MD 21629 23a. Part 1. Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ REVAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CARTUVASCULAR DISCASE ASTHOROSCLOPPOTIC Secure tially list of a little of Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last DIABETES Hospital or Attending Physician; The law requires that the death certificate be executed MELLITUS sician and burial-trans attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No ed by the a detached f Yes been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 2 🗌 No this certificate 1 Yes Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 St Other (Specify) PROPILE House Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 🔀 Natural 5 \square Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29h. Signature and title of ce 12/3/2012 DO057509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENTON, MD ZIEZ9 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 9 4 2012 wer son Registrar

DHMH 17 Rev 7/2009

Gj

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Marylar Registrar	nd / Depa	artment of Hertificate of De	ealth a	and M		-	112	4169	0			
			Decedent's Name (First, Middle, Last)		tinoato or B	Odtii		2. Date of De							
	Physicia Medic		Monica Rose Anfang					Month December	Day r 10,	Year 201.2	0417	М			
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L					County of Death					
المسب		Л	Holy Cross Hospital			ver S			Montgomery						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ı <i>y, Year)</i>	9. Birth	olace (State or Fore try)	ign			
ds	Director		None 1 □ M 2 👺 F Usual Residence of Decedent	Yrs.		1	2	December	10, 2012	Mar	yland				
	and show	itor	10a. State 10b. County 10c. Cit	ty, Town or Lo	cation	1	0d. Inside City Lim	iits							
	Maryl 28a-f otifie	Director	Maryland Frederick		Point of	Rock	s		1 ☐ Yes 2 🛣 No						
	a or be no	D D	10e. Street and Number	-	10f. Zip Code				10g. Citizen o	f What Cour	ntry?				
	h witl ns 23 nust	Funeral	3878 Gibbons Road		217	777			United S	States of	of America				
	r iten		11. Marital Status 12. Was Decedent Ever in U. Armed Forces?		Vas Decedent of His f Yes, specify Cuban,	panic Orig , Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		ace - Americ lack, White,					
920	al", o	d by	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates,	1	☐ Yes 2 🕱 No	Specify:		Speci	fy: Whi	ite					
ŏ	hours natur lical E	Completed	15. Decedent's Education		lent's Usual Occupat				16b. Kind of	Business/In	dustry				
212	in 72 e. nan "ı Med	dmc	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give I life. D	kind of work done du O NOT use retired)	ring most	of workii	ng			,				
2	ygien gien ner th		0	<u> </u>	None					None					
nd	be filed within 72 hours after death with the Maryland and all-tygiene. ked at laty fisher than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)						Maiden Surna	me)					
Š	should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		Chris Anfang	_			ichel								
Maryland 21215-0036	of Health and Ment of Health and Ment fitem 27 is marked r other traumatic e		19a. Informant's Name/Relationship (Type, Print) Chris Anfang / Father	1	-	Address (Street and Number of Address Road, Poin			-		Code)				
ď.	l and 2 s f Health s tem 27 other tre		20a. Method of Disposition 20b. F	Place of Dispo	sition (Name of				20c. Location		own, State				
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot				natory or other place) 1's Cemetery	D		er 13, 12			aryland				
alti	mit. F partm porta y inju		21. Signature of Funeral erv Licens		Name and Address					LICK, M	атутаци				
m	De di i		MO:	1433 1 1	eeney & Basi 06 East Chu	cora i rch St	reet.	uneral i Frederi	iome ick. Marv	land 21	701	3			
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.				-				Approximate Interval Between				
F	h, sician/		Immediate Cause (Final disease or condition Multip	le Fetal	Anomalies						Onset and Death				
Medical resulting in death) a. Due to (or as a consequence of):															
		er	Sequentially list conditions, b. Due to (or as a consequence)							-					
	ed nsit	Examiner	if any, leading to immediate Due to (or as a consequences. Enter Underlying Cause. Enter Underlying Cause (Disease or injury	uence or):											
	xecur n and al-tra	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of the con	uence of):											
09	certificate be executed inding physician and use as the burial-transit	dical	d												
9/8	incate in grant by a street as the	Med	IF FEMALE:												
χο : ×	n cerr tendir or use	an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live Birth 2 Feta		Ectopic pregnancy					Date of deliv	*				
Rox	the atte	Physician/Me	1 Pregnant at time of c		Other (specify)				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	/lonth	Day Year				
л. Э. :	law requires that the death certifics has been signed by the attending p e 2 should be detached for use as i		Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause give	n in Part I		23e Did to	ohacco use co	ntribute to th	ne cause of death?				
ι, T	res tr signe d be (d by									bably 4 🗆 Unkno				
or o	requ been shoul	lete						24a. Was	an 24t	. Were auto	osy findings availab	ole			
Ö.	rsician; The law I	Completed						auto _l perfo	psy ormed?	prior to co death?	mpletion of cause of	of			
E 1	an; II tificat tor, p		25. Was case referred to medical		26. Plac	e of Deat	h (Check	1 Yes	2 & No	1 Yes	2 L No				
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oto	ng Ph fter th ineral		27. Manner of Death 1 X Natural 5 Pending 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work?				now injury occu						
<u>.</u>	tendi leath. tor: A the fi	ifica	2 Accident Investigation		M 1 □ Y	es 2 🗆	No								
Division of Vital Records,	or Atter of Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At he building, etc. (Specify		et, factory, office		2	28f. Location (S City or Tou		ber or Rural	Route Number,				
<u> </u>	To the hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowl	ledge, death o	ccurred at the time	date and	place an	d due to the ca	ause(s) and ma	nner as stat	ed.	- 1			
:	n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of r	n and/or invest	igation, in my opinion,	, death oo	curred at	the time, date a	and place, and o	due to the ca	use(s) and manner s	tated.			
	vith To th		29b. Signature and title of certifier		29c. License r	number	_		29d. Date sign	ed (Month,	Day, Year)				
	AL		m do oct		1072	29	2		1811	011	8				
	1510		30 Name and address of person who completed cause of death (Item Darwana Theresa Ratleff, M.D. 1500	, , , , ,	,	Fores	- (1-	Max-1	and 20010						
	Stat					orest	- Grei	r, rentyle							
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's grant	garks											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 4169 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 2012 2:29p Bertha Marie Bramble Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Elkton Cecil If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 😾 F Months Hours (Month, Day, Year) Country) **Director** 219-20-5232 88 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at Director 1 X Yes 2 No MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 604 Elkton Blvd. 21921 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 XNo Black White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 ▼ Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Walters Ethel Milburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Bramble/ Son 604 Elkton Blvd. Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/18/12 Home, Foard Funeral Rising Sun, 22. Name and Address of Facility R.T. Foard Funeral Home, 259 E. Main St. Elkton, N Signature of Funeral Service Licens uchaso 23a. Part 1. Enter the disease, or complishock, or heart failure. List only on ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): g physician a Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a d be detached f 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed' 1 Yes 2 No 2 N Yes To the Hospital or Attending Physician: " within 24 hours after death. To the Funeral Director: After this certifics 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) funeral director Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ☐-Natural 5 Pending work? 1 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

7 r

32. Registrar's Signature

BOW St. EIKton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 heod

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22:03 Physician/ Y2:01 Da 2 8 Menth Deborah Beyrer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges Prince Georges General Hospital Cheverly Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 7-18-1968 Days Hours Mir 217-06-4836 44 **Director** 1 M 2 XX Washington D.C. Usual Residence of Decede 28a-f show with the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits notified at Director XX Yes 2 No Bowie Maryland Prince Georges 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral US items 23a 20716 15507 Hall Rd. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc ò 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medit
once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederick J. Miller Ruth A. Buckland 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1815 Lagle Rock Lane
Frederick, Md. 21702-5911 19a. Informant's Name/Relationship (Type, Print)
Melissa L. Rowley Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Barnabas Cemetery 12/4/2012 Upper Marlboro, Md. 4 Donation 5 Other (Specify) Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 16000 Annapolis Road Bowie, Md. 20715 M00544 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ CARDIAC FATAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events routhing in dootb). Lock Examine HEART FAILURG ONGESTIV use as the burial-trar Due to (or as a consequence of) resulting in death) Last ding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) ō in the past 12 months?

1 Yes 2 No Month Day Year the a Pregnant at time of death 9 Unknown s been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe this certificate 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2)X No 잍 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 \square Pending work 24 hours after death. Funeral Director: At M 1 Yes 2 No Accident Investigation 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year)

State Registrar HOSPITAL BRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MAYO

DEC 03 2012

31. Date filed (Month, Day, Year)

Director 217 46 7386 18 M 2 F 64 Yrs. Months Days Hours Min. 12/28/1947 Company Min. 12/28/1947 Company Months Days Hours Min. 12/28/1947 Company Min. 12/28/	ath PS Intriplace (State or Foreign ountry) MD Intriplace (State or Foreign ountry) MD Intriplace (State or Foreign ountry) Intriplace (St				
Physician /Medical Examiner Funeral Director Physician / Medical Examiner 1. Decedent's Name (First, Middle, Last) Thomas Allen Butler 2. Date of Death Month Day Year 4 2012 4a. Facility Name (If not institution, give street and number) 2168 Pineview Court Waldorf 5. Social Security Number 6. Sex 217 46 7386 Director Puneral Director Social Security Number 217 46 7386 Director Puneral Director Social Security Number 217 46 7386 Social Security Number 217 46 7386 Social Security Number 32 7. Age (In yrs. last birthday) 15 Under 1 Year 16 Under 24 Hrs. Months Days Hours Min. Min. Month, Day, Year) 12/28/1947 Usual Residence of Decedent	3. Time of Death 12:45P M ath 2:S Inthibiace (State or Foreign ountry) MD 10d. Inside City Limits 1 Yes 2 No ountry? erican Indian, te, etc.				
Thomas Allen Butler 4a. Facility Name (If not institution, give street and number) 2168 Pineview Court 4b. City, Town, or Location of Death Waldorf Charle Social Security Number 217 46 7386 Charle 7. Age (In yrs. last birthday) Director Charle 12 17 46 7386 Usual Residence of Decedent	the state of the				
2168 Pineview Court Waldorf Charles Funeral Director 217 46 7386 Sex MS M 2 F 64 Yrs. Usual Residence of Decedent Usual Residence of Decedent Waldorf Charles Waldorf Charles Waldorf Charles Funeral Months Days Hours Min. Min. Min. Min. Min. Min. Min. Min.	Principlace (State or Foreign ountry) MD 10d. Inside City Limits 1 Yes 2 No ountry?				
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Director Solution 217 46 7386 18 M 2 F 64 Yrs. World's Days Hours 12/28/1947 Usual Residence of Decedent	MD 10d. Inside City Limits 1				
Total State 10b. County 10c. City, Town or Location MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What C 2168 Pineview Court 20601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of Work done during most of working 16b. Kind of Business	1 反 Yes 2 □ No ountry?				
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2168 Pineview Court 20601 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give Mod Voir Moder during most of working)	te, etc.				
Armed Forces? Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whi	te, etc.				
15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working	.acr				
(Specify only highest grade completed) (Give kind of work done during most of working	Business/Industry				
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Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Private 8 To publish to the first private of the first					
To set to see the second secon	nasir sarramo,				
The property of the property o	Zip Code)				
Cynthia Douglas/Daughter 2168 Pineview Ct. Waldorf, MD 206	01				
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place)	Town, State				
200. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Mary's Cat. Cem. 12/12/12 Bryantown					
20a. Method of Disposition St. Mary SCat.Cem. 12/12/12					
2294 Old Washington Rd. Waldorf					
shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Approximate Interval Between Onset and Death				
/Medical disease or condition resulting in death) disease or condition resulting in death)					
Examiner Sequentially list conditions	:				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
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FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month					
GO OF The standard of the stan	Day Year				
	to the cause of death?				
1 Yes 2 No 3 F	robably 4 Unknown				
24a. Was an 24b. Were a	utopsy findings available				
The state of the s					
Geath? Tell 1 1 1 1 1 1 1 1 1 1	3 2 2010				
25. Was case referred to medical examiner? 1 Yes 2 No	ecify)				
C C C Selection (Month, Day, Year) Injury Work?					
The state of the s	Rural Boute Number				
27. Manner of Death 1	ididi i i data i i dina di				
Compared to the control of the con					
29b. Signature and title of certifier 29d. Date signed (Mon	nth, Day, Year)				
D25352 12-4-	12				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OR ROX 2729 SPIGE MD 206 Ub					
State Registrar 31. Date filed (Month Day, Year), 2012 32. Jegistrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	1 - State Registrar	Certificate of Death	Я	eg. No. 2012 41694					
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Deat December						
	Medic	al	Elizabeth Frances Bowers								
	Examin	er	4a. Facility Name (if not institution, give street and number) Williamsport Retirement Center	4b. City, Town, or Location of De Williamspo		4c. County of Death Washington					
11.0	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 H	rs. 8. Date of Birth	9 Birthplace (State or Foreign					
	Director		217-42-9057 1 D M 2 🗓 F 67	Months Days Hours M	Jan. 31	, 1945 Country Maryland					
	d t	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits					
	a-f sh	cto	West			1 ☐ Yes 2 ₩ No					
	or 28;	Dire	Virginia Berkeley 10e. Street and Number	Falling Waters 10f. Zip Code		10g, Citizen of What Country?					
	with t	Funeral Director	70 Dorchester Drive	25419		USA					
	leath items ier m	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - American Indian, Black, White, etc.					
9	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	d by	Armed Forces? 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 X No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: White					
3	atura cal E	Completed	3 Widowed 4 L. Divorced Year or Dates. 15. Decedent's Education 16a.	Decedent's Usual Occupation		16b. Kind of Business/Industry					
212	n 72 h an "n Medi	ldmo	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done during most of v life. DO NOT use retired)	working	,					
7	withi			Homemaker		Home					
ng	e filed ital Hy ed oth even	To Be	17. Father's Name (First, Middle, Last) Francis Reid Saunders		Name (First, Middle, M	, and the second					
$\frac{8}{2}$	d Mer d Mer mark matic					ngan City or Town, State, Zip Code) 25419					
Maryland 21215-0036	2 sho Ith an 27 is r traun		115			aters, West Virginia					
ď.	and Hea		20a. Method of Disposition 20b. Place of	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or Town, State					
Ë	Page nent c int: If iry or		Burial Cremation 3 Hemova from State		.14,2012	Sharpsburg, Maryland					
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or ot		21. Sign aure of Faneral Series access	22. Name and Address of Facility	sborne Fu	neral Home, P.A.					
20	9 Q E 8 9		Cert Sh			illiamsport, MD 21795					
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	O:		est, Approximate Interval Between Onset and Death					
4	Medical		Immediate Cause (Final disease or condition resulting in death)	Charian Carcina	mè	Zyears					
	Examiner		Due to (or as a consequence o	ŋ:		,					
	Barry	ner	Sequentially list conditions, if only, leading to financially.	0:							
	uted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c								
	executed ian and urial-transi	E E	resulting in death) Last Due to (or as a consequence of	f):							
3760	tificate be executed ng physician and sas the burial-transit	Medical	d								
89	± D g	_	IIF FEIVIALE.	_		23d. Date of delivery					
Rox	requires that the death cert been signed by the attendir should be detached for use	Physician/	in the past 12 months? 1 Live Birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year					
	that the death ned by the atte e detached for	hys	g ☐ Unknown								
	s that gned be dei	ρ	a latti. Other significant conditions contained by	the underlying cause given in Part I.		bacco use contribute to the cause of death?					
dS,	requires been sign should be	Completed			1 □ Y						
Ö	law e 2	Mg/m	·		— 24a. Was a autop perfor	sy prior to completion of cause of					
ž	The ate pag			00 Plant of Partle #	1 Tes						
/Ita	ysician: is certific director,	To Be	examiner?	26. Place of Death (C		ence 6 Other (Specify)					
ot/	g Physer this					ow injury occurred					
on	tending lath. tor: After the funer	fical	1 Accident Investigation (Month, Day, Year) If	M 1 Yes 2 No							
Division of Vital Records,	r At fter c irect n by	Certificate:	3	m, street, factory, office	28f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)					
	urs urs ral	ī	T T	death occurred at the time, date and pla	ce, and due to the ca	use(s) and manner as stated.					
	To the Hosp within 24 ho To the Fune completely f	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the best of my know	r investigation, in my opinion, death occur	red at the time, date ar	nd place, and due to the cause(s) and manner stated.					
	To the COTTR		29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)					
	1		Totalle MD	033700		December 10, 2012					
71	1-5		30. Name and address of person who completed cause of death (Item 23a) (Ted Howe MD 154 W, ARTICA		A report	D 21795					
. N	Sta	10		NST, WILLIAMS	KOKCI, IV	W 2111					
	Registra		31. Date filed (Month, Day, Year) 32. Begistrar's Signature	Barel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 41695 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Robert Bell 2339 December 2018 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Talbot Memorial Hospital Easton 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Country) Director 216-40-4854 1 🕅 M 2 □ F 69 March 28,1943 Md. Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaniner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 √ Yes 2 No Caroline Md. Henderson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21640 U.S.A. 109 Bell Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 fork lift operater food processing Bell, Robert Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Bell Pauline Louise Stubbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley C. Bell (wife) 109 Bell St. Henderson Md. 21640 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Chesapeke Crem. Cntr. Dec.8,2012 Chester Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 106 w. Sunset Ave. Fleegle-Helfenbein F.H. Greensboro Md.21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) eax1 Medical Due to (or as a consequence of): Examiner ease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Phones after death.
Funeral Director: After this certificate has been signed by the attending physician and ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical ROY Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed secondary by perpasaltyroides 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 ☐ Yes 2 ☐ No Yes 2 N within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital |₽ 1 🗌 Yes 2 💢 No 1 Inpatient 2 KER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, dath occurred at the time, date and place, and due to the cause (s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0046020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8579

DHMH 17 Rev 06-201

State Registrar 31. Date filed (Month, Day, Year)

DEC 0 6 2012

ORIGINAL

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cuart Decembe 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation o Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In yrs. last billhday) Salisbure Wicomico If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Days Months Director 041-42-2540 1 X M 2 □ F 65 7-4-1947 Usual Residence of Decedent Connecticut an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a State 10h County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 S. Heron Drive 21842 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, <u>the Me</u>ury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home Administrator Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Cuart Helen Rudnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alicia Cuart - Daughter 201 S. Heron Drive, Unit F9, Ocean City, MD 21842 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place. Important: It any injury or 4 Donation 5 Other (Specify) Crematory of Delmarva 12-7-2012 Delmar, Delaware 21. Signature of Faneral Service License 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part . Enter the disease, or comp shock, or heart failure. List only on ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1. Enter the disease, or complic Immediate Cause (Final Opset and Death Physician disease or condition resulting in death) Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examir requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ₩☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an The law 1 ☐ Yes 2 ☐ No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be B 26. Place of Death (Check only one) examiner? ٩ 1 🔲 Yes 2**V** No Other 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a At title of certific Day, Year) 6TC who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mont State Registrar

DHMH 17 Rev 06-2011

James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per FH C938 4/18/2013 JH
State of Maryland/ Department of Health and Mental Hygiene

1 - State Amend #1 per MD g942 8/19/13 TRT
Certificate of Death

Reg. No 2 0 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month \ Physician/ 3:49AM Day Robert H. Christopher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Alluntor 6 mm Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 05/13/1940 219-36-5223 **Director** 72 1**XX**M 2 □ F 3/13/1940 Cambridge, MD Usual Residence of Decede shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director DE 28a-f New Castle Newark 1 🗆 Yes 2 🏝 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 19711 86 White Clay Crescent USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. or þ 1 Never Married 2XXMarried 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 white 1 Yes 2 No Specify: "natural", Specify 3 Divorced 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Engineer DuPont Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnarne) ည Cecil Irene Todd Robert H. Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19711 Patricia C. Christopher (wife) 86 White Clay Crescent Newark, DE 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State McCrery & Harra Crematory 12/12/2012 Wilm., DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee W00 22. Name and Address of Facility McCrery & Harra Funeral Homes & Crematory, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Myorardia Ph_sician/ ē disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due (Ir as a consequence of) 3 Dellow with and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical 13/1940 as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery Box (in the past 12 months? Month Day Year 2 No 9 Unknown 9 Unknown DOB: 51 Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autonsy performed? Yes 2 No death? Robert 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending 1 Natural injury work? 5 Pending ours after death.

eral Director: Af

filled in by the fu М 2 🗆 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check red at this term, data a Curtifying Nurse Practitioner: To the best of my knowle 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C10001161 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 324 East 31. Date filed (Month, Day, Year) State Registrar

Pop:Ry

Christopher,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 25, Physician/ Preston Coolidge Crowl 2012 3:30 p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Westminster Ridge Westminster 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Mar 25, Min. °f925 1 **X** M 2 □ F Maryland 219-20-1399 87 Director Usual Residence of Decedent show 10d Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State Director 1 Yes 2 No Westminster Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 filed within 72 hours after death with USA 505 High Acre Drive iral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give WWTT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Lant: If item 27 is marked other than "natural", ury or other traumatic event, the Medical Exal white WWII 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) County Government Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Eva Flickinger William H. Crowl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 505 High Acre Dr, Apt 218, Westminster, MD 21157 Ethel L. Crowl, wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of I Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 12/1/2012 St. Mary's Cemetery Silver Run, MD 4 Donation 5 Other (Specify) 21. Signative of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis St, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ar many Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or iinjury Examine Date for as a c use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal use ☐ Pregnant at time of death Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year for Month Day 2 🗌 No the a per 9 Unknown 9 Unknown as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρΛ 1 Yes 2 No 3 Probably 4 Unknown Hospital or Attending Physician; The law requires Division of Vital Records, Completed Les Mellitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to dical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Mannel f Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00050763

Registrar

DHMH 17 Rev 7/2009

6+1VA

State

ERNESTO M.

31. Date filed (Month, No. V)

32. Pagistrar's Signature

824 WASHINGTON RD. STE. 120.

WESTMINSTER, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. MENDOZA

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 State of Maryland Department of Health and Mental Hygiene 2 1 2 4 6 9 9

		_	State of Maryland 7 Dep State Registrar Ce	rtificate of D		nentai mygie Reg	2012	41699				
	Physicia		Decedent's Name (First, Middle, Last) Jesse R. Chaves			2. Date of Death Month	27, 2012	3. Time of Death 3:00 p M				
	Medic Examin		4a. Facility Name (if not institution, give street and number)		Location of Death	110131302	4c. County of Dear	th				
أدميه	Funeral		205 St. Mark Way Apt 502 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	ninster If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	Carr 9. Bir	thplace (State or Foreign				
	Director		030-10-9030 225-30-4325	Months Days		ode Island						
	yland •f show ed at	ctor	10a. State 10b. County 10c. City, Town or L	ocation	Westmin	etor		10d. Inside City Limits				
	the Mar or 28a e notifi	Director	10e. Street and Number	10f. Zip Code			. Citizen of What Co	1 X Yes 2 □ No ountry?				
	th with ms 23a must b	Funeral	205 St. Mark Way Apt 502		21158	- 14 - V	US					
926	e filed within 72 hours after death with the Maryland ta Hygiene. A superstand that Hygiene. Sale of Sale f show ed other than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates.	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 No	n, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit Specify:					
15-0036	72 hour r"natur edical	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupa	ation during most of work	ing 16	b. Kind of Business/Industry					
212	within giene.		Elementary/Secondary (0-12) College (1-4 or 5+) 5+	DO NOT use retired) Engineer		E	ederal G	overnment				
and	be filed ental Hy ked oth ic event	To Be										
Maryland 2121	I and 2 should by I Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) Personal 19b. Mai	ty or Town, State, Zi								
	t and 2 f Health item 27 other to		20a. Method of Disposition 20b. Place of Disp	Sawgrass position (Name of Manday or other place			c. Location - City or					
Baltimore,	: Page tment o tant: If jury or		4 □ Donation 5 □ Other (Specify) Carroll	Crematory	11/2		Winfield,					
Bal	permit. Pag Departmen Important: any injury once.		21. Signature of Inneral Service Ucenege Audio Lawid Madok	22. Name and Addres	ss of Facility My s Street,	ers-Durbo Westmins	raw Funer ter, MD 2	al Home 11157				
	nysician/		Rent 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death				
-,	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	0.01				granter then				
L		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	2/\				greates then				
	ecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):	esity				5415				
09/	certificate be executed inding physician and use as the burial-transit	ledical I	a Atrial Fib	sillatio	\wedge		545.					
189	certifica inding p use as t		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	☐ Ectopic pregnanc			23d. Date of de	elivery				
. Box	he death y the atte iched for	Physician/N		Other (specify)	-y		Month	Day Year				
s, P.O	To the Hospital or Attending Physician: The law requires that the death certification thin 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part I.	1		o the cause of death? Probably Unknown				
Scor	law req has bee je 2 sho	Completed				24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of				
ਤ ਕ	ian: The rtificate ctor, pag	Be Co	25. Was case referred to medical examiner?	26. Pl	ace of Death (Chec	1 ☐ Yes 2		s 2 No				
Ĭ	Physic rthis ce eral direc	욘	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 28a. Date of injury 28b. Time		4 ☐ Nursing H	ome 5 🕅 Residence		cify)				
ouo	eath. or: After the fune	Certificate:	1 Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	work			many occurred					
Division of Vital Records,	alor Att s after d al Direct		4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,				
	ne Hospit n 24 hour le Funera pletely fill	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practitioner: To the best of my knowledge.	estigation, in my opinio	on, death occurred a	t the time, date and p	place, and due to the	cause(s) and manner stated.				
_	Within Sorie		29b. Signature and title of certifier	29c. License		1	Date signed (Mont					
	PC		30. Name and address of person who completed cause of death (Item 23a) (Type, Tu0174 A. 5TAN BAUGH. 826 WASHIN	Print)		nistan.	SEPEN M	D 21157				
	φ Sta	te	31. Date filed (Month, Day, Year) 32. Register's Signature	0100	3, , , ,	, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	- 3/5/0)					
	Registra		NOV 2 9 2012 Denous A.	Markel								

Physician. Medical Examiner

physician and that the death certificate be

P.O. Box 68760

Division of Vital Records,

To the Hospital or Attending Physician: The law requires: within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be

	21. Signature of Funeral Service Licensee	Lyler	22. Name and Address of 630 South				vice ,VA 20132				
	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not cause on each line. Due to (or as a consequence of	Q2 55.00		respiratory arrest,		Approximate Interval Between Onset and Death				
Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of									
ysician/Me	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of document in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of document in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Month 9 Unknown										
Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Clark Litting Anamia. Alumation death but not resulting in the underlying cause given in Part I. 1 23e. Did tobacco use contribute to 1 Yes 2 No 3 Property of the prior to contribute to 24a. Was an 24b. Were authority to contribute to 25c. Did tobacco use contribute to 25										
Com	***************************************				autopsy performed? 1 \square Yes 2	death?	completion of cause of				
Be	25. Was case referred to medical examiner?		26. Place	of Death (Check o	nly one)						
힏	1 Yes 2 No	ospital:	patient 3 DOA Other:	4 Nursing Home	e 5 🗆 Residence	6 Other (Spec	ifv)				
Medical Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Tir inj	me of 28c. Injury at work?		d. Describe how inj						
al Cert	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	and Number or Ru te)								
Medica	(Check 2 \(\sum \) Medical Examine	ian: To the best of my knowledge, der: On the basis of examination and/or Practitioner: To the best of my knowl	investigation, in my opinion, :	death occurred at th	e time, date and place	ce, and due to the	cause(s) and manner stated.				
_	29b. Signature and title of certifier		29c. License nu	mber	29d. D	ate signed (Monti	n, Day, Year)				
	KA RUNN			782		12 04	2012				

State Registrar Regional haspital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 12 8:21 pm Condon 2012 **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EIKTON Ceci HOSPi Union If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Security Number Funeral 256-24-6291 86 Yrs GA Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director reci i 1 Yes 2 □ No 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 🗆 Yes 2 No Specify: White Specify: 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker OWN home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Highsmith Aldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Pierce Rising Sun Fay Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State EVANS Cremation Service 12-3-2012 Leola, 4 ☐ Donation 5 ☐ Other (Specify) 86 Fine St 21. Signature of Funeral Service Licenses Edward L Collins, 5r. Funeral Home, Inc. Oxford A 19363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYUCARDIAL INFARCTION STELEVATION Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner fl any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been sinced to the control of the cont tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 ☐ Yes 2 № 9 ☐ Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural work? 1 ☐ Yes 2 ☐ No 5 Pending after death 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 8:33 pm MD D7368 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 , BOW STREET ELKTON MP21921 KIRAN K BAIKATI MD 31. Date filed (Month, Day, Year) . Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Cartwright **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 □ M 2 🙀 F 263-70-1944 68 Director 03/16/1944 Virginia Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10a. State 10h. County 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at 1 TyYes 2 □ No Director MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 La Plata Rd. 20646 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify White ģ 3 Widowed 4 Divorced Year or Dates: "natural" Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disability 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If item 27 Is marked ot any Injury or other traumatic ever James A. Cartwright Dorothy Ivey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Butler/Guardian 200 Kent Ave., La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 12/10/12 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service License 22. Name and Address of Facility Raymond Funeral Svc., P.A. M01517 5635 Washington Ave., La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DIYOTIYU **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner and I-transit death certificate be executed Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the as 1 the attending IF FEMALE. for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) P.0. signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ nestension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy page Bipolos di surdes Dementia performed 2 No Division or Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the f 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

the

Registrar's Signature

30. Name and address of person who completed cales of death (Hem 23a) (Type, Print) hon Blud, Glen Burne, mi), 2106

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0506AM Monto / 06 / 2012 Year Jov Ann Dodson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Harford Memorial Hospital Havre de Grace 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👽 F Hours Maryland 0 99 99 49 49 47 65 Director 220-52-3055 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Havre de Grace Maryland Harford 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21078 U.S.A. 310 Alliance Street Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1 Never Married 2 Married 1 Ves 2 No If Yes, Give 21215-0036 Specify: White 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Secretary CLerical 12 Be V. Father's Name (First, Middle, Last) Walter Scott Hodges 18. Mother's Name (First, Middle, Maiden Surname)
Doris Gray ပ Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print)
Mark Dodson (son) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
510 N. Adams St. Havre de Grace, MD 21078 permit. Page 1 and 5 Department of Healt Important: If item 2 any injury or other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State West Chester, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/7/2012 | Pennsylvania RA Ferris & Co 22. Name and Address of Facility Zellman Funeral Home, P.A. S.Washington St.Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE STROKE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RESIRATORY Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 Ø No Dav Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ⊭ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires the hours after death. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has funeral director, page 2: autopsy Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 🗹 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Anatural 2 Accident iniury 5 Pending Investigation completed filled in by the 124 hours after deat e Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) tion Street Havre de Grace MD 21078 egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Felisa Deasis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Doctors Hospital Lanham Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Days Hours **Director** 212-25-7119 86 1 □ M 2 🗶 F May 17,1926 **Phillipines** show filed within 72 hours after death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Bowie Prince George's 1 Yes 2XXNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13108 Crutchfield Avenue 20720 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2xx No Specify: Specify: Asian Deas.S 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) 6 Own Home Homemaker Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Dionisia Villaverde Consorcio Cada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13108 Crutchfield Avenue, Bowie, MD 20720 Leonides Valle/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State Baltimore, MD Dec.6,2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death NEUMONI Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: Certificate: To 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending iniury Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title 29d. Date signed (Month. Day, Year, MDD 58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway, SuiteB Greenbelt, MD. 20170

DHMH 17 Rev 06-2011

State Registrar

7219 Hanover

Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ DASCH JR Month 6 LOUIS Medical 11 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BATIHORE WARITNETON MEDICAL CENTE AA GLEN BURNIE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Davs Hours 219-44-7670 1 X M 2 □ F 67 Director 02/27/1945 Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1020 Springhill Way 21054 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14 Race - American Indian 1 X Yes 2 No If Yes, Give Vietnam Year or Dates. Armed Forces
1 X Yes 2 or Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Govt 12 Signal Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis G. Dasch Sr. Mary Elizabeth Herlth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Dasch/Spouse 1020 Springhill Way Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 12/02/2012 Glen Burnie,MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Sal Hardesty Funeral Home P.A. 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ATHEROSCLERATIC CANDIDVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, DIARETES HELLITUS RENAL FAILURE 24a. Was an Hospital or Attending Physician; The law performed' Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? 1 → Yes 2 → No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Watural 5 Pending ours after death.

leral Director: Aft
filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Baltimore, MD

White

709 PM

Year

2012

Interval Between Onset and Death 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 🗌 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 036033 11/29/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1132 Annapolis Road Suite 201 Odenton, MD 21113 ORIGINAL

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0 4 2012

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Yo the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification:	2 Accident 3 Suicide	6 Cou	stigation and not be ermined	28e. Place o	f Injury - At	home, fa	rm, street,	factory, office	building, et		or Town,	State)	d Number or Ri	ural Route Numb	er, City	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rosa Lucille Dickson ²/2012 12/1 12:00 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Washington Hospice Capitol Heights Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 579-42-0913 5/16/1924 Director 1 🗆 M 2 🕮 F MD Usual Residence of Decedent Pege 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Heelth and Mentel Hygiene.
ant: If Item 27 is merked other then "neture!", or Items 23e or 28e-1 ehos ury or other treumetic event, the Madical Examilyer must be natified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5504 Decatur Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Statistical Clerk - DOL Government 12±h Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Unknown Sadie Viola Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Dickson/son 5504 Decatur Street, Hyattsville, MD 20781 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 e
Depertment of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery: 12/10/2012 Snowen 21. Signatur of uneral Service 22. Name and Address of Facility Mo1576 246 N. Washington Street, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death

6 Weeks Immediate Cause (Final Physician disease or condition resulting in death) Aspiration Pneumonia Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director After this certificate has been signed by the ettending physicien and complishely filled in by the funeral director, page 2 should be deteched for use as the buriel fragist. that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical BB 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) ᅙ 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 IDOA Hospice 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Way, Largo, MD 20774 Sureshchandra Desai, Shital 31. Date filed (Month, Day, Year) State DEC 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KIVIETTE DANIELS 11/27/2012 <u>15:30</u>P ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 2100 Country Pines Court Waldorf Charles If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 579-98-2545 Director 49 1 M 2 X F 08/11/1963 DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or no none. 10a, State 10c. City. Town or Location Director 10d. Inside City Limits MD Charles 1 X Vas 2 No Waldorf 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 2100 Country Pines Ct. 50707 **NZA** Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Completed by Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Specify If Yes Give Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Program Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph Daniels Rosa Mae Scutchings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurent Boudias / husband 2100 Country Pines Ct., Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Memorial Cem. 12/03/2012 Waldorf, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signat re 6500 Allentown Rd., Camp Springs, MD 20748 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 158 Ce Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician as the burial Physician/Medical requires that the death certificate be Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No the detached 1 ☐ Yes ∠ g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Was an this certificate has autopsy perform Yes 2 A-No 1 Yes **Division of Vital** Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1/No 1 Tes ည 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1- Natural work? 5 Pending within 24 hours after death.

To the Funeral Director Af completely filled in by the fu 2 Accius 3 Suicide Accident Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifi 29c. License number CL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

29

State Registrar 32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Jean A. Dempsey December 0630 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci1 Calvert Manor Healthcare Center Rising Sun Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Hours Director 219-36-0467 1 □ M 2 🗶 F SEPT 23, 1932 Usual Residence of Deced 80 Pennsylvania 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Pennsylvania Chester Lewisville 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country er than "natural", or items 23a or the Medical Examiner must be Funeral 960 Chesterville Road 19351 United States hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🏋 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Il Hygiene. (Give kind of work done during most of working life. DO NOT use retired Cosmetics Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other the any injury or other trainmast. Shipping Department Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Russell Davis Anna Pierson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest W. Dempsey/Husband P.O. Box 130, Lewisville, PA 19351 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State December 6, 4 ☐ Donation 5 ☐ Other (Specify) Oxford Cemetery 2012 Oxford, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final and Death irrhosis Physician disease or condition menown Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi). Exami burial-transi Due to (or as a consequence of): resulting in death) Last physician To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 🗌 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) 2 No 1 Tes Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signature and tit

D0023322

12.3.2012.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 23a per med cert G936 2712/13 dk
State of Maryland / Department of Health and Mental Hygiene 2 1 2 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Da**0**4, Physician/ December Bessie Schumm Fetterman 2012 9:53 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 541 Franklin Street Perryville Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
_ **Funeral** 7. Age (In yrs. last birthday) Days 1 M 2 V F Months Hours 218-22-0832 90 **Director** Yrs 922 Marvland Sept Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Perryville Cecil 1 X Yes 2 No 10e Street and Number 10g. Citizen of What Country? 5 10f. Zip Code 23a Funeral with 348 Elm Street 21903 U.S.A. items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry V.A.Maryland Health Care System Perry Point, Maryland (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med within 7 Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Human Resource Specialist Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Schumm pe Bessie Yocum permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 541 Franklin Street, Perryville, Maryland 21903 Ginger Eastridge (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Hopewell Cemetery 12/09/12 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766 Sign rure of Funeral Service Licen is 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_si_ian Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year been signed by the a should be detached to P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate has yes 2 No 2 No 1 Yes 25. Was case referred to medica or Attending Physician: funeral director, **Division of Vital** 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence day the Specify) residence 2.12 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1) Natural 28c. Injury at 28d. Describe how injury occurred After injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide completed filled in by determined City or Town, State) within 24 hours a Hospital Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nume Practionary the best of my knowledge coefficient of the time, date and place and the tothe cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) randes 30. Name and address of person who completed cause of death (Item 23a) (Type 6 THOMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Effie D. Faucette 05 37 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel . Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Maryland Jun 14, Year) 1929 Days Min 216-22-3268 Director 1 □ M 2 🛣 F 83 Usual Residence of Decedent show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 X No 10e Syzet and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with USA 605 McKinsey Park Drive Unit# 201 21146 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 ☑ Widowed 4 ☐ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland 12 Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Buckman Frances Vacek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Mavis/Daughter 705 Lynngate Road Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 4, 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State ec. 2012 Cedar Hill Cemetery Baltimore, MD 4 Donation 5 Other (Specify) 21. Sinature of Funeral Service License P.A. Severna Park Funeral Home 495 Ritchie Hwy. Severna Park, MD 21146 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 2. Part 1. Enter the disease, or con shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate cause (Final Physician/ NSTEMI disease o condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ESRO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulting in death). Leaf Examine Due to (or as a consequence of) DM and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate I Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1, Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drine, Glen Burnie Yasir Tamad Hospital State 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Decembs وسو 2012 7.40 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MEDSTAR MARSOR MOSPITAL RALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 217-24-2344 1 □ M 2 🕅 F 83 11/27/1929 Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Edgewater 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 431 Hamlet Club Drive, #206 21037 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. If Hygiene. ۵ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3XXWidowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Homemaker Home should e filed v and Mental Hyg is maried othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wilbert F. Cook Mabel E. Cummings permit. Page 1 and 2 should e Department of Health and Men Important: If item 27 is mar e any injury or other traumatii 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Hettenhouser/Dau. 2561 Stow Court, Crofton, MD 21114 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🕅 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 12/3/12 Edgewater, Maryland 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Pregnant at time of death Day g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting Prijectian. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Descripting Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Re 00072328 who completed cause of death (Item 23a) (Type, Print) MEOSTAR WAR GOR MOSPITAL BALTIMORE MD NURTO CHIVA

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBEL 20 20 12 Sylvia G. Garrison Medical . Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHEN KUPNIE PALTIMOPE WASHINGTON MEDILAL CENTER ANNE 8. Date of Birth (Month, Day, Y Aug 24 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) **Funeral** Months Year 216-22-3494 Director 1 □ M 2 🛣 F 1927 Maryland 85 ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severn 1 🗌 Yes 2 🏋 No Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21144 416 Queenstown Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give JACASou, SyLVIA Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: Black 3 X Widowed 4 □ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16b. Kind of Business/Industry
Anne Arundel Co. 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Public School's 4yrs Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oscar Gaither Sarah Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellicott City, Md.21042 9650 Ashmede Dr. Rosalyn R. Stroble(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 12-10-12 Metro Crematory Baltimore, Md. 4 Donation 5 Other (Specify) 21, Signature of Funeral Service Licenses Winame a Recessor F& Will Sons Mortuary, Larry 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or hings) Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events executed and -trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending r as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? Director: After this certificate I 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🖪 No Other: မှ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending death. 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature 29c, License number 1)45149 Drember 29 201: ause of death (Item 33a) (Type, Prin ame and address of person who complete se Glau Burne Mi NABA oistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Melvin H. Gabourel Sr. Dec. 2. Day 2012 Year 11:02 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 926 Autumn Wood Drive Gambrills Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Director** 579-34-1356 1 XM 2 □ F 82 June8,1930 Washington DC Usual Residence of Deced 10a. State the Maryland 10b. County 10c. City, Town or Location at Director 10d. Inside City Limits r 28a-f st notified a MD Prince George's Capitol Heights 1 ☐ Yes 2X No 10e, Street and Number ō 10f. Zip Code ems 23a or must be r 10g. Citizen of What Country? Funeral 6404 Rolling Ridge Drive 20743 USA "natural", or items edical Examiner mu 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1XXYes 2 □ No Army If Yes, Give Year or Dates. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 XXVidowed 4 Divorced **Black** Completed I Hygiene. other than "natur rent, the Medical E Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Director of Bureau of Engraving Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked ot r other traumatic ever မ Joseph Gabourel Lillian Montigue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Paulette L. Gabourel/Daughter 926 Autumn Wood Drive Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or once. ō cemetery, crematory or other place) MD Vet. Cem. Dec.11,2012 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 5d Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 Part 1. Enter the disease, or complicati ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one ca Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and the burial-transit that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the attending IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 - Fetal death for in the past 12 months?

1 Yes 2 No Pregnant at time of death Month been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s this certificate has autopsv performed' 1 Yes Yes 2 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? daughter 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6XX Other (Spec 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 3 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Yea

State Registrar

101

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) H

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Wayne Gar	1	ner - For State legistrar	State of	Maryla		-	rtment o			Mental	Hyg		eg. No.	20	12	4171	
Physician	1	 Decedent's Name (First, I 							_			Date of Dea	ith	Year	- 1	3. Time of Death	
Medical Examine		Robert Wayne 4a. Facility Name (if not inst			mber)			4b. City.	Town, or L	ocation of De		Month Decembe		012 . County of D	eath	1700 1115	
		6907 Fulford Stree			,			Clint						rince Ge		3	
Funeral	•	5. Social Security Number	6. Sex		7. Age (In	yrs. la	st birthday)	If Und	ter 1 Year						oreian		
Director		220-42-3837	1 <u>X</u> _M	2_ F		6	8 Yrs		ns Days	Hours	Min.	05/03	/19		Cour	ntry) MD	
any	_	Jsual Residence of Decede 10a. State 10b. Con			10c	City,	Town or Local	tion								10d. Inside City Limits	
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the Maryland a or 28a-f show tiffed at once.	3	10e. Street and Number					·	10f. Zi	Code			1	0g. Citi	zen of What	Count	ry?	
r death with the Maryland or items 23s or 28s-f sho must be notified at once. Furneral Director	3	6907 Fulford	Street						2073	35			USA				
er death with i	200	11. Marital Status 1 Never Married 2	Married 1	2. Was Dec Armed F		r in U.S				anic Origin? Mexican, Pu			10- 14. Race - American Indian, Blace White, etc.				
her des		3 X Widowed 4	Divorced If	Yes Yes, Give Yea		No	1 1	Yes :	X No	specify:			e				
ours aft atural" xaming		15. Decedent's Education	(Specify only	Dates: highest grad	de complet	ed)	16a. Deceder			on (Give kind				Kind of Busin			
16 n 72 h nan "n ical E		Elementary/Secondary (0	1-12)	College (1	I-4 or 5+)		-		orking life. I	JO NOT use	retired)	In	ternal	ernal Revenue		
5-0036 ed within 72 hour stygiene. other than "natur the Medical Example Computered.	5 -	12 17. Father's Name (First, Mi	ddle Last)	4			Auditor					irst Middle		Service			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than every, the Medica		William Ralph		iner					18.Mother's Name (First, Middle, Maiden Surna Mary Imogene Perrie								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hand Montal Hygiene. Insportant Witten 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Firmeral Director	19b. Mailing Address (Street and Number or Rural Route Number, C															Zip Code)	
MD and 2 sho salth and cen 27 is raumati		Krista L. Key	ysar/ I	Jaugnt		20h P	lace of Dispos					ete La La ,		Location - Ci		own State	
Baltimore, pernit. Pages I ar Department of Hee Important: If ite	Н	1 X Burial 2 Crem		Removal fr	am Stata	C	rematory or of	her place	•)	-					-		
nit. Pa arimen ortani		4 Donation 5 Other 21. Signature of Funeral Se		9	11	J L •										Home, PA	
Per Dep	1	i must C	Ela	1	MOO	945				A 57 LaP					:La.	nome, i A	
Physician	1	23a. Part I. Enter the diseas failure. List only one c			aused the	death.	Do not enter t	the mode	of dying, s	uch as cardi	ac or re	espiratory ar	rest, sho	ock, or heart		Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final dis or condition resulting in dea		pertensi		_	cular Dise	ase							_	Death	
Mary mark por	П	Sequentially list conditions,	, DG	e to (or as a	Conseque	siice oi,	<i>,</i> .										
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50, te be execut ysician and burial - tra		UNPENDED		AMENDED	outcome o	f pregn	ancy						23	d Date of de	livery		
D.O. Box 6876; that the death certificate ned by the attending phy detached for use as the t	2	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 23d. Date of delivery Month Day Year															
lox (eath or attent for use		1 Yes 2 No 9	Unknown	9 Unkn	nant at time own	e of dea	ath 5 O	ther (Sp	ecify)				1				
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Records, The law require: ficate has been sig. page 2 should be												24a. Was auto	psy	pric	r to co	ppsy findings available impletion of cause of	
Recorded the same of the same	إ											1 ✓ Yes	rmed?	lo 1	ith? ✔ Yes	2 No	
Vital Rec ysician: The his certificate director, page		25. Was case referred to me examiner?		pital:					10	of Death (Ch			1 =				
n of Vii ding Physia After this funeral dire	- 1-	1 ✓ Yes 2 No 27. Manner of Death		28a. Date	of Injury	2 🔃	ER/Outpatien 28b. Time of		DOA 28c. Injury					ury occurred		Scene	
on cending sath. or: Af			Pending	(Month	ı, Day,Year)				1	es 2 No	,						
Division of Vital Records, pital of Attending Physician: The law requiremental entered to the Attending Physician: The law requiremental Director: After this certificate has been stilled in by the funeral director, page 2 should the Contribution: To Re Committee	3	2 Accident 3 Suicide 6	Investigation Could not be	28e. Plac	e of Injury	- At ho	me, farm, stre	et, factor	y, office bu	ilding, etc.	28	or Town,		and Number	or Rur	al Route Number, City	
Spital hours of filled of filled		4 Homicide 29a. Certifier 1 Certifyi	determined	(Specify)													
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours abter death. To the Pureral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the I Madiral Certification: To Ref. Completed by Physician/M	2	Check only					je, death occu nd/or investiga										
To To Con	2	29b. Signature and title of c	erhifier aı	nd manner s	stated.			25	c. License	number			29d.	Date signed	(Mon	th, Day, Year)	
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Dr X,		Laron Locke MD.			/		900 W. B			Baltimor	e. MC	21223	_				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Day 2012 Doris Lillybelle Goltz 1:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Broadmore Senior Living Hagerstown Washington . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sep. 16,1923 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛛 F Days 557-28-0070 89 Louisiana **Director** Usual Residence of Decedent 28a-f shov 10h. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Nebraska Lincoln North Platte 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 801 West Philip St. 69101 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", Completed 3 XWidowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pastorial Assistant Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Acey Herbert Kent Anna Barbara Neuvander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn S. Childerston-daughter 19224 Jamestown Dr. Hagerstown, MD 21742 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory 12-12-2012 Smithsburg, MD 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph_sician/ Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year been signed by the should be detached Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 No 1 🗌 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital 2 1 NO Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of the Funeral directions of the funeral directions. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h Signature and title of certifier -0056413 12/11/2012

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Humphreys Loceal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mardela Springs 320 Bridge Street If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours (Month Day, Year) 3-18-1949 1 □ M 2 🛛 F 63 **Director** 225**-**76-5956 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location irector Wicomico Mardela Springs ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 320 Bridge Street 21837 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ģ 1 Never Married 2 XMarried ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Head Housekeeper Be 17. Father's Name (First, Middle, Last) ျှ Albert Edwin Sales, Sr. Ethe1 Mae 19a. Informant's Name/Relationship (Type, Print) and 2 s Gary Humphreys – Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gd. 12-10-2012 22. Name and Address of Facility . Signature of Funeral Service Ligensee Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. Immediate Cause (Final Physician/ hronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): ng physician and as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No to Pregnant at time of death 5 Other (specify) ned by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ should be The law requires 1 Yes Records, Completed 24a. Was an page 2 s autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending 1 Yes ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and the of certi 29c. License number

ress of person who completed cause of death (Item 23a) (Type, Print)

mn

Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> Medica1 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box_104 320 Bridge Street, Mardela Springs, Maryland 21837 20c. Location - City or Town, State Hebron, Maryland Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Yes 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

2012

Wicomico

USA

Specify:

14. Race - American Indian, Black White etc.

11:24 P™

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 No

Delaware

White

Registrar DHMH 17 Rev 7/2009

State

30. Name and add Hlon

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3. Time of Death DECEMBER Physician/ W. Hooke Sr. James М Medical 2012 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL TENINSULA Med ICAL Center 31213641 KICOM ICO 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 219-10-0475 Director 1 X M 2 | F 88 02/22/1924 Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo rei", or Items 23e or 28e-f a Examiner must be notified 1 🗆 Yes 2 🔀 No Maryland Wicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34364 Main St. 21850 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give AirForce Year or Dates irForce 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 X Married filed within 72 hours after altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Major in Military U.S. Air Force t. Pege 1 end 2 should be filed with triment of Health end Mental Hygier rtent: If Item 27 is marked other 1 njury or other treumetic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Robert E. Hooke Gertrude D. Tierney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Hooke/Spouse 34364 Main St., Pittsville, MD 21850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 3-22-13 oortent: | Arlington National Cametery Pending 4 Donation 5 Other (Specify) Arlington, permit.
Deperting Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Wom 501 Snow Hill Rd., Salisbury, MD 21804 M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate has been signed by the ettending physicien end irector, pege 2 should be detached for use as the burlal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 🛭 To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certification of the Funerel Director. After this certification of the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital: 1 Yes 2 💢 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 X Natural 2 Accident 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) K14013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jill R. Porter, CRNP 1820 Sweetbay Dr., Suite 101, Salisbury, MD 21804 31. Date filed (Month Da), egistrar's Signati State Registrar

Adme	end i	ιtε	em#19a-Ceci p le	se type of Pri	REM'Black I	ndelible in	k. Ensure	All Copie	es Are Legible	e.
		-	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I rtificate of I		Mental Hy	/giene Reg. No.2 0 1 2	41719
Р	hysicia		1. Decedent's Name (First, Middle Marian Kat		aas			2. Date of De Month Decemb	Dav _ Year	3. Time of Death 2:30 A M
	Medic Examin		4a. Facility Name (if not institution	give street and number)		4b. City, Town, o	r Location of Death		4c. County of De	
	uneral		5. Social Security Number 221–07–2323		je (In yrs. last birthday) 101 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth 9. B	irthplace (State or Foreign ountry)
	rector	١	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ncation		106/28/	/1911 Mai	ry I and 10d. Inside City Limits
Marylan	28a-f shotified	irecto	DE New C	astle	Middlet	cown				1 ☐ Yes 2 🛣 No
with the	s 23a or nust be r	Funeral Director	10e. Street and Number 1210 Dutchnec	k Road		10f. Zip Code 19709)		10g. Citizen of What C	Country?
0036 urs after death	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 🔀 Widowed 4 ☐ Divorced	If You Give	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 💢 No	an, Mexican, Puert	pecify Yes or No o Rican, etc.)	Black, Wh	
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nd 21	other th	8	3 17. Father's Name (First, Middle, I	ast)	Wa	itress	18. Mother's Nar	me (First, Middle	Restaura	nt
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hydiene.	marked matic e	٥	William W. Ber		n d c on 19h Maili	na Address (Street		Mae Wa		Zin Code)
e, Ma and 2 sh	em 27 is ther trau		19a. Informant's Name/Relationsl John F. Domin: 20a. Method of Disposition	ick IV /			rive, El			
Baltimore, permit. Page 1 and Department of Hea	tant: If its ury or of		1 🙀 Burial 2 🗌 Cremation 4 🗍 Donation 5 🗎 Other (S		20b. Place of Dispo cemetery, crei Rivervie	matory or other pla		Date 2/2012	20c. Location - City of Wilmington	
Balt permit	Important in once.		21. Signature of Funeral Service L	Strou		Strano and Address 635 Churc	Feeley F	amily F	uneral Home ark DE 1970) 2
Division	sician/		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	inly one cause on each lin	e.					Approximate Interval Between Onset and Death
М	ledical aminer		disease or condition resulting in death)	Due to (or as	ONGESTI a consequence of): TMAL f	SAA. HIZ	AICT F	AILURA		
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68760 certificate be	g physic as the bu	Nedica		d						
က ဗ	y the attendin sched for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3	☐ Ectopic pregnan☐ Other (specify) _	cy		23d. Date of d Month	lelivery Day Year
s, P.O.	signed b	2	Part II. Other significant condition	ons contributing to death t	out not resulting in the	underlying cause gi	ven in Part I.		tobacco use contribute Yes 2 No 3	to the cause of death? Probably 4 Unknown
Records, The law requires	nas been e 2 shoul	Completed						24a. Was	opsy prior to	autopsy findings available o completion of cause of
tal Re	artificate ctor, pag		25. Was case referred to medical examiner?			26. P	lace of Death (Che	1 🗌 Yes	900 4	es 2 🗆 No
of Vital	er this ce neral dire	욘	1 Pes 2 No 27. Manner of Death	28a. Date of inju		f 28c. Injur	4 ∐ Nursing F y at		idence 6 Other (Spe	ecify)
Division tal or Attendings after death.	c tor: Aff by the fur	Certificate:	Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	gation not be	y, Year) injury ury - At home, farm, str		Yes 2 No	28f. Location	(Street and Number or F	tural Route Number,
Divi	eral Dire			Physician: To the best of		occured at the time	date and place a		wn, State)	tated
thin 24 h	the Fun	Medical	(Check 2 Medical E	xaminer: On the basis of e Nurse Practioner: To the	examination and/or invest	stigation, in my opini	on, death occurred ne time, date and pla	at the time, date	and place, and due to the	e cause(s) and manner stated. as stated.
P S	1 00		P- V- N ~ Y				65733		12 / 11 (12	
2	4		30, Name and address of person	who completed cause of c	leath (Item 23a) (Type, I	A. EMT	HIGH	5 Meu	t, rikro	<i>ب</i>
F	Stat Registra	e	31. Date filed (Month, Day, Year)	32. Registr	death (Item 23a) (Type, I	par				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WOr 1314PM Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death 8. Date of Birth (Month, Day, Year) Mar. 13, 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign Days 218-26-5949 Months Min. Maryland Hours 82 Director 1 🛣M 2 🗆 F 1930 Mar. 10c. City, Town or Location 10b Count 10d. Inside City Limits Carroll County Direct Maryland Hampstead 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral United States 3195 Shamer Lane 21074 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 24 No Black White etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) factory industrial engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell MacKay Hollingsworth Maude M. Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, D. Lynn Zielezinski/daughter 2700 Sterling Point Drive Portsmouth, VA 23703 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State cemetery, crematory or other place Hampstead Cemetery 1 X Burial 2 Cremation 3 Removal from State Injury c Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South Main Street M01072 Hampstead, Maryland 21074 urm 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SMALL BOWEL OBSTRUCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner METASTATIC CARCINOID CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of). Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant Box (23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 No ate has been signed by the page 2 should be detached Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier ppaun MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POONAM PATEL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 30 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	•	rtment of H tificate of D			liene Reg. No. 20	12	41721
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Deat	th	Year	3. Time of Death
	Physicia Medic	al	Eleanor Elizabeth Howes		# 00 F	Lucation of Death	12/	2/2012		0818 M
	Examin	er	4a. Facility Name (if not institution, give street and number) AAMC		4b. City, Town, or I			4c. County Anne	e Aruno	de1
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year)	9. Birthpla Country	ce (State or Foreign
	Director		212-58-8075 Usual Residence of Decedent 91	Yrs.			3/11/1		I	MD
	land show dat	tor	10a. State 10b. County 10c. City, 7	Town or Loc					100	I. Inside City Limits
	Mary 28a-1	Director	MD Anne Arunde1		Churchton	n		10g. Citizen of V	Mhat Countr	1 Yes 2xxNo
	with th		5701 Blaine RD.			20733		_	JSA	, .
The part of the pa									e - American ck, White, etc).
-00	hours a natural	Completed	35 Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education	16a. Deced	ent's Usual Occupa	tion		16b. Kind of B		
Maryland 21215-0036	thin 72 sne. than "I	Somp	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	life. DC	ind of work done du NOT use retired) Seamstre		ry	C1	Lothin	p
d 2	illed wi Il Hygie I other vent, tl	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I			5.
ylar	ild be f Menta narked latic e	은	Russell Phipps			Emma_Ki				
Mar	2 shouth and the and the results in the traum.	33	19a. Informant's Name/Relationship (Type, Print)		g Address (Street a			•		de)
ē,	1 and of Heal item 3			ce of Dispos	Blaine R sition (Name of natory or other place		hton, Moate	20c. Location		n, State
altimore,	Page ment c ant: If ury or		Bunai 2 X K remation 3 Removal from State	ntic (Crematory	12/4	/2012	Glen H		
Balt	permit. Depart Import any inj	12	21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death.	12	Name and Address Ridgely	Ave. Ar	napolis	, MD 21		P.A.
T. A.	Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the	nce of):	o'c Card	rdi'ovas Vovasu	ular c	chiseas This eas	se se	Onset and Death
). Box 68760	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnand 1 Live Birth 2 Fetal of 4 Pregnant at time of deady 10 Unknown	death 3 ath 5	Other (specify)			Мс		lay Year
s, P.O.	res that signed I		Part II. Other significant conditions contributing to death but not result The Sting Penforat		nderlying cause give	en in Part I.				cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by it completely filled in by the funeral director, page 2 should be detach.	Completed by	Diabetes Mellitus T Dementici		Two		24a. Was a autop perfor	rmed?		y findings available pletion of cause of
tal	ysician: T is certifica director, p	Be	25. Was case referred to medical examiner?		26. Pla	ice of Death (Check	only one)			
ίV	Physion this contains and the	2	27. Manner of Death 28a. Date of injury 2	R/Outpatier 28b. Time of	nt 3 🗆 DOA	4 L Nursing Ho	me 5 Resid			
o uc	nding ath. r: After	icate	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	work'	? Yes 2 🗆 No				
ivisi	or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow		er or Rural F	Poute Number,
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowler only one) 3 Certifying Nurse Practitioner: To the best of my	and/or invest	tigation, in my opinio	 n. death occurred at 	the time, date a	nd place, and du	ue to the caus	e(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	0 -	29c. License			29d. Date signe	ed (Month, Da	
	10		30. Name and address of person who completed cause of death (Item 2		Print) GYF	N C.				2751
	· W		5851 - Deale Church 31. Date filed (Month; Day Year) 1010 & Registrar's Signature) Road	y 'De	ale	M. D) 20	161
	Sta Registr		31. Date filed (Month: Day Year) 2012	par	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Calvin Merritt Hopkins AM 2:10 Dec Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Talbot The Pines HealthCare aston If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Date of Birui (Month, Day, Year) Funeral Months Davs Hours Min Country 1 🔀 M 2 🗆 F 214-32-0509 80 Director 1932 Maryland Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County death with the Maryland Director must be notified Caroline Preston MD 1 Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21655 items 23a Funeral United States 22291 Hog Creek Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Examiner Armed Forces?

1X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 X Married "natural", or þ Salvin Hopkins Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 53-55 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Fishing/Crabbing Waterman 11(Grad Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Hopkins Lulu Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22291 Hog Creek Road, Preston, MD 21655 Virginia Hopkins/Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Hurlock, Maryland 12/11/12 4 ☐ Donation 5 ☐ Other (Specify) Eastern Sh. Veterans Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, Federalsburg, MD 21632 216 N. Main St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** MRANS Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached fin use as the burnal transit. Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

DEC 0 7.2012

Name and address of person who completed cause of death (Item 23a) (Type, Print) MO

DHMH 17 Rev 7/2009

610

32. Registrar's Signature

29c. License number

DUTCHMANS

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #25 State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3-20 Ruth A. Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Nicomico Salisbury oastal Hospice at Lake If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) Days Months Min. (Month, Day, Year) Director 219-74-5543 1 ☐ M 2**X**☐ F MD 5-11-1940 72 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Princess Anne MD Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11974 Edgehill Terrance 21853 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 ☐ Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: SpecifyBlack Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Housekeeping Be treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jong မ Moody W. Jones Florence White permit. Pege 1 and 2 should be Depertment of Health and Man Importent: If Item 27 Is merke any Injury or other treumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7499 Barton Ave, Salisbury, MD 21801 Julia Garrison/Niece Baltimore, ath 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State (Venton) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) UM Cem 12-8-2012 Princess Anne, Trinity 21. Signatule of Funeral Service Licensee Isabella St. 22. Name and Address of Facility Bennie_Smith 917 W. Funeral Home Salisbury, MD 21801 Part 1. Euler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final ment and Duth Neuro muscular Disease Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events Due to (or as a consequence of): been signed by the ettending physicien end should be deteched for use es the burlei-transit Exam thet the deeth certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day 9 Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cardiomegaly Records, 1 Yes 2 No 3 Probably 4 Unknown Completed pege 2 should Cerebral palsy 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy perform hes this certificate Yes 2 of Vital or Attending Physicien: funerel director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 X Yes 2 □ No Hospice မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending injury Division To the Hospitel or Attendir within 24 hours efter death. To the Funerel Director: Af completely filled in by the fu death. 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Prot)

Thunawill - Shrehan DD PD Box 1733 Salusbury, MD 31. Date filed (Month Day egistrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_akiesna Jacks		1- For State Registrar			ent of Hea ate of Dea	alth and Meni ath	tal Hyg		, No. 2	012	2 4172
Physici Medical Exam		Decedent's Name (First, Middle,Last Lakisha Patric	•	on				Date of Death Month	Day `	Year	3. Time of Death 0615 hrs
		4a. Facility Name (if not institution, give			4b. City	, Town, or Location of		November		ity of Death	
		Peninsula Regional Medic		- 05 - 1 - 15		sbury			Wicor		
Funeral Director		5. Social Security Number 6. Se 193-56-0913 1 Usual Residence of Decedent		je (In yrs. last bir		ths Days Hours	Min.	5 – 3 0 – 1		Foreign	hplace (State or n untry)PA
aoy		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
Maryland 28a-f show	tor	MD Wicomic	0	Salisk	oury						1 Yes 2X No
ne Mary or 28a- fied at	Director	10e. Street and Number				ip Code			g. Citizen of	What Coun	try?
death with the Maryland or items 23a or 28a-f sho must be cotified at occ.	ra D	8225 Jersey Ro	ad 12. Was Decedent	Ever in U.S.		804 dent of Hispanic Orig	in? (Specif		ISA Tia Ra	ace - Americ	can Indian, Black,
death or item	Funeral	1 Never Married 2 Married	Armed Forces			cify Cuban, Mexican,				hite, etc.	Sair Iridiani, Diack,
s after	þ	3 Widowed 4 X Divorced	If Yes, Give Year or Dates:			2X No specify:				y:Blac	
72 hour	eted	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	College (1-4 or		Decedent's Usua during most of w	al Occupation (Give k orking life. DO NOT	(ind of work use retired)	done	16b. Kind of	Business/Ir	ndustry
5-0036 led within 72 hours after Hygiene. other than "ontoral", the Medical Examiner	Completed	12		Ma	anager				вв&т		
21215-0036 uld be filed within 7 Mental Hygiene. marked other thao	Be Co	17. Father's Name (First, Middle, Last) Arnold Bickers	r-ee		-		-	rst, Middle, Ma		ne)	
2121 ould be fi I Mental I marked	70 B	19a. Informant's Name/Relationship (Ty		19	o. Mailing Addres	ROCI SS (Street and Num		Cham Route Numb		own, State,	Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natoral", or items 23a or 28a-f she injury or other traumatic eveot, the Medical Examiner must be sottlifed at once	11 3	Harmony Bicker	staff/Da	aughter	216 D	avis Str	ceet,	Sali	sbur	y, MI	21801
Baltimore, oemit. Pages I and Department of Heal Important: If iten of Jury or other tra		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from St	ate 20b. Place of cremate	of Disposition (Na ory or other plac	ame of cemetery, e) Cem	Da	ate	20c. Locatio	n - City or 1	Town, State
Itim iit. Pag urtment ortsot:		Donation 5 Other Specify: 21. Signal re of Funeral Service Lice	ha .		ng Hill	Gard	12/8	3/2012	Hebro	on, N	MD
Depa Imp	1	Querel for	5		Benni	d Address of Facility e Smith al Home	91/ Sali	W. Is sburv	abel.	1a St 218()1
Physician /Medical		23a. Part I. Enter the disease, or compl failure. List only one cause on each	cations that caused	the death. Do no	ot enter the mode	of dying, such as ca	rdiac or res	spiratory arres	t, shock, or	heart	Approximate Interval Between Onset and
xaminer		_	Multiple Injuries								Death
		Sequentially list conditions, b	ue to (or as a conse	equence or):							
	iner	if any, leading to immediate Cause. Enter Underlying Cause	ue to (or as a conse	equence of):							
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Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	UNPENDED	AMENDED		·						
760 Teate b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregnancy					23d. Date	of delivery	
Box 687: death certific.	ician	past 12 months?	1 Live birth 4 Pregnant at	time of death 5	=		pregnancy		Month	Da	ay Year
BO he deat y the at hed for	Physician/	Part II. Other significant conditions	9 Unknown								
, P.O.	à	Part II. Other significant conditions	contributing to death	n but not resulting	in the underlyin	g cause given in Par	t I.				he cause of death?
rds, require been si	Completed							24a. Was an			opsy findings available
Recol The law icate has	ф							autopsy perform 1 Yes 2	ed?	death?	ompletion of cause of
	Be	25. Was case referred to medical		1		26.Place of Death (Check only]	No	1 Yes	2 No
f Vit	리	examiner? 1 Yes 2 No 27. Manner of Death		nt 2 🗹 ER/Ou				ome 5 R			
Division of Vital Records, tal or Atteodiog Physiciae: The law require its after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending	28a. Date of Inju (Month, Day Y Nov 27, 2012	ry 28b. 1 ear) 0300	Time of Injury hrs	28c. Injury at Work? 1 Yes 2 ✓	le ut	l. Describe ho oject assau		Demu	
ViSic or Atto fter dez Directo	ificat	2 Accident Investigation 3 Suicide 6 Could not b	28e Place of In	ury - At home, fa	rm, street, factor	y, office building, etc		Location (Str	eet and Nun	nber or Rur	al Route Number, City
Spital cours a filled	Ser	4 Homicide determined		and on porch			Fou	or Town, Sta nd 29202 De	te) oubletree [Orive, Sali	sbury, MD
Division of Vital To the Hospital or Atteodiog Physiciae: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical		n: To the best of my On the basis of exar and manner stated	knowledge, dea nination and/or ir	th occurred at the	e time, date and plac y opinion, death occ	ce, and due urreo at the	to the cause(time, date an	s) and mann d place, and	er as stated due to the	d. cause(s)
	Σ	29b. Signature and title of certifier		-	29	c. License number					th, Day, Year)
	}	30. Name and address of person who co	mpleted cause of de	eath (Item 23a)		O.C.M.E.			Novembe	л 28, 201	12
5TC		Carol H. Allan, MD Assis	tant Medical Ex	caminer 90	0 W. Baltimo	ore Street, Baltir	nore, MI	21223			
St Regist		31. Date filed North, Dyne 2012	2. Registrar	's Signaure	arkel						
DHMH 17 Pay 1/2/	204	"de PA de 5 de									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For 1 - State Registrar	State of Mary		artment of F tificate of D		Mental Hyg	liene leg. No. 20	12	41725
	Dhusisia	/	1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat	th		3. Time of Death
	Physicia Medic			ones				Month December	2nd	Year 2012	5:35AM
	Examin	er	4a. Facility Name (if not institution, give			4b. City, Town, or		h	4c. County		orgo!g
ممرر	Funcual		Forestville Nur 5. Social Security Number 6. Se		yrs. last birthday)	Forest		8. Date of Birth			eorge's
	Funeral Director			THE DE	7 Yrs.	Months Days	Hours Min.			NC	
	D wo		Usual Residence of Decedent 10a. State 10b. County		On City Trust and an						
	ryland Ied a	cto			c. City, Town or Loc					110	0d, Inside City Limits 1 🙀 Yes 2 🗌 No
	or 282	Dire	MD Prince_ 10e. Street and Number	George's	Distri	10f. Zip Code	nts		10a. Citizen of W	/hat Count	- 21
	with th	Funeral Director	2130 Rosyln Ave	nue		20747			USA	mar oou	.,,.
	items er mu	Fun	11. Marital Status	12. Was Decedent Ever		as Decedent of Hi				- America	
36	", or i	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		☐ Yes 2 X No		o Rican, etc.)		_{k, White,} e Blac	
3	ours atural	Completed	3 XWidowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates.		ent's Usual Occupa					
5	an "na Media	mpl	(Specify only highest gra		(Give k	ind of work done d NOT use retired)	uring most of wo	rking	16b. Kind of Bu	siness ind	ustry
7.	withir giene er thi		Elementary/Seconday (0-12) 4th	College (1-4 or 5+)	Toba	cco Fari	mer		Privat	:e	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) William Smith			-		me <i>(First, Middle, N</i> ne Peti	,)	
چ	nould the not mark		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin			ıral Route Number,		tate. Zip C	ode)
ž	nd 2 sh ealth a n 27 is er trau	ĺ	Gene Barnes/Son	1				l. Wilso			
ore	ge 1 ar t of He If iten or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State		atory or other place			20c. Location -	•	vn, State
Baltimore,	nit. Pag artmen ortant: injury	1	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License		[amilton]						
ра	Department Important		21. Signature of Fulleral Service License	tes	17.2	6 Tarbo	oro St	milton W Wilson	Funera	il Ch 7893	napel
	· ·		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the							Approximate Interval Between
- 4	nysician/	8 9	Immediate Cause (Final disease or condition		andiopu	almonary	Colla	pose			Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):						DAYS
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):	le ceres,	of Aver	y inter	etion	-	73
	uted Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	c. Es	Ft Middlensequence of: sential	Hypert	ten sion	า			Years
	Lor Attending Physician: The law requires that the death certificate be executed after death. alterdeath. blacetor: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	al Ey	resulting in death) Last	Due to (or as a co	nsequence of):						
00/	cate be physic the b	edical		d							
8	certific nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy				23d. Date	e of delive	v
BOX 08	death ne atte ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at tim 9 Unknown		Other (specify)	/		Mon	nth I	Day Year
л Э	at the d by th etache		9 ☐ Unknown Part II. Other significant conditions co		ot resulting in the ur	nderlying cause giv	en in Part I	230 Did toh	2000 USD CORTI	huta to the	e cause of death?
ν, T	ries th signe	d by				,g g		1 🗆 Ye	-1		ably 4 🗆 Unknown
Vital Records,	requi	lete	Dysphagio Dementia					24a, Was ar	24b. W	Vere autop	sy findings available
ပ္သ	ne law te has age 2	Completed	Advance A	0.0				autops perforr	ned? pi	rior to con eath?	pletion of cause of
<u> </u>	an: Th	Be C	25. Was case referred to medical	9 -		26. Pla	ce of Death (Che		2 DKNo 1	☐ Yes 2	2 12-100
N N	nysici nis cer I direc	To E	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	lospital: 1	2 ER/Outpatient	: 3 DOA Othe	r: 4 Nursing I	lome 5 Reside	nce 6 🗆 Other	r (Specify)	
101	ling Pl I. After th funera	ate:	27. Manner of Death 1 ★ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	ar) 28b. Time of injury	28c. Injury work	at	28d. Describe ho			
SIO	Attend death ctor: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, stre		Yes 2 □ No	28f. Location (Str	reet and Number	r or Rural F	Route Number
DIVISION	al Or A		4 Homicide determined	building, etc. (S		,,		City or Town		0, 1,0,0,1	iodo (tambol)
_	Hospit 24 hour Funerated fill	Medical	(Check 2 L Medical Examir	ician: To the best of my ner: On the basis of exam	ination and/or investi-	gation, in my opinio	n, death occurred	at the time, date and	d place, and due	to the caus	se(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as completed filled in by the funeral director, page 2.	ž	only one) 3 Certifying Nurse 29b. Signature and title of certifier	e Practioner: To the best	t of my knowledge, de	eath occurred at the 29c. License	time, date and pl	ace, and due to the	cause(s) and mar 9d. Date signed	ner as sta	ted.
	P 5 P 0		K. Photol-	Timo			52865		0		-d 2012
	20-2		30. Name and address of person who co	proplete d seuse of double	(Item 23a) (Type, Pr	int)					
	An,		K. Michael Figa- 31. Date filed (Month, Day, Year)	0 -0 1215	Signature	polis Rd	suite 2	so Glen	n Dale, 1	MD	20769
	Stat Registra		DEC 0 7 20	12 January	B. Da	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:35 AM Louis Jones Docember 14 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore-Washington Medical Center Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 253-04-7661 Director 1 **⊠** M 2 □ F 73 11/20/1939 Mississippi 28a-f shov filed within 72 hours after death with the Maryland al Hygiene. dother than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Annearundel 1 SYes 2 No Odonton, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1307 Hallock Drive 21113 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces 1 ☐ Yes 2 🗷 No If Yes, Give Black White etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9th Self-Employed Contractor Paving Construction æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental မှ Levi permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once. Jones Evelyn Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell A. Jones 1311 Greyswood Rd., Odonton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope Cemetery 12/18/2012 | Florence, SC 22. Name and Address of Facility Myrtle Beach Funeral Home, Inc. 21. Signature of Funeral Service Licensee James D. LOFDE, 3454 4505 Hwy. 17 Bypass So., Myrtle Beach, SC 29577 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burlansit mapletely filled in by the funeral director, page 2 should be detached for use as the burlansit mapletely filled in by the funeral director, page 2 should be detached for use as the burlansit mapletely filled in by the funeral director, page 2 should be detached for use as the burlansit mapletely filled in by the funeral director, page 2 should be detached for use Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown 5 Other (specify) 4 Pregnant a Pregnant at time of death Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ŕ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 1 No ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ᅆ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending 1 Tes 2 🗌 No Investigation Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 W Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) K107529 December 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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HOSPITal

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			Pleas amen	e Type or Pri	nt in Bla	pck Indelible In 935 1-17-13 Department of OCME 3717 of	k. Ensure	All Copie	s Are Legi	ible.
			For State Registrar	Amend 23a	aryland? \$25 pe i	Certificate of l	lealth and Death		giene Reg. N. 20	12 41727
	Physicia Medic		1. Decedent's Name (First, Middle, I	chael		Jackson		2. Date of De	ath Der 22	3. Time of Death 8 14 P M
2	Examir	ner	4a. Facility Name (if not institution, g The Johns #17	ive street and number) PKINS H	ospita	al Bouth	r Location of Dea	city	4c. County	of Death
	Funeral Director		222-44-2521	. Sex 7. Age 1	(In yrs. last b	irthday) If Under 1 Year Months Days Yrs.	If Under 24 Hr Hours Min	s. 8. Date of Bir Month, Da	y, Year) 1954	9. Birthplace (State or Foreign Country) PENN Sylvania
	ryland I-f show ied at	ctor	10a. State 10b. County DE 10b. County	- GV		wn or Location		JUNE	1,100	10d. Inside City Limits
	th the Ma 3a or 28a t be notif	Funeral Director	10e. Street and Number	-	1-111	10f. Zip Code	1963	1	10g. Citizen of W	
	eath wi	nue	16981 KUST	12. Was Decedent E	ver in U.S.	13. Was Decedent of H	ispanic Origin? (S	Specify Yes or No-		- American Indian,
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?, 1 Yes 2 If Yes, Give Year or Dates.	No	If Yes, specify Cuba 1 ☐ Yes 2 💋 No		rto Rićan, etc.)		k, White, etc.
21215-0036	nin 72 ho ne. :han "nat e Medic s	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		+)	Decedent's Usual Occup (Give kind of work done of life, DO NOT use retired)	during most of wo		16b. Kind of Bu	siness/Industry CA+10~
	ad witl Hygier other 1	BeC	17. Father's Name (First, Middle, Las	0	1 +	cop Service		ame (First, Middle,		
lan.	i be filed fental Hy rked oth	뎯	George W.	·	J				ougher	L .
Maryland	should be file n and Mental I ris marked o raumatic eve		19a. Informant's Name/Relationship	-		b. Mailing Address (Street		and the same of th	_	
	and 2 Health Iem 27		MARY Lou J	ACKSON		6981 Rust of Disposition (Name of	RS. 14	Date		
E	Page 1 nent of ant: If it any or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Soc	Removal from State	Cemet MILS	ery, crematory or other place	A 7~	c. 7 7812	M. IF	City or Town, State
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Funeral Service Lid			22. Name and Addre	ss of Facility	102 Lak	evento	e My Horell, DE
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	mplications that caused one cause on each line	the death. Do	not enter the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	mysician/ Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	of):			11	and the same of th
-	Examiner	<u>.</u>	Sequentially list conditions,	b. Rabacto	1	Tempora bornia		N.V	BYMEDICAL	EXAMMEN
	ted Insit	Examiner	if any, leading to immediate cause. Enter Unidentitying Cause (Disease or injury	Due to (or as	onsequence	eof):		CERTIFICATION APP	3010	
	executed ian and irial-transit	I— I	that initiated events resulting in death) Last	Due to (or as a	consequence	of):				
760	ath certificate be attending physici for use as the bu	edica		■ d. <u>Metron</u> treatme	nt for	psoriatic at	chritis	act resu	ilting fi	rom
Box 68760	h certifi tending or use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	of pregnancy 2 Fetal dea	th 3 D Ectopic pregnance	ev .	U	23d. Date	e of delivery
). Bo	the deat by the at ached fo	Physician/Medica	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 Other (specify)	•		Mon	th Day Year
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ecor	e law rei has be ge 2 sh	Completed						24a. Was a autop	sy pr	ere autopsy findings available ior to completion of cause of eath?
E T	an: Th tificate tor, pa		25. Was case referred to medical	1		26. PI	ace of Death (Che	1 🗆 Yes		Yes 2 No
Z.	hysici his cer al direc	욘	examiner? 1 XYes 2 44e			Outpatient 3 DOA Other	or.	Home 5 ☐ Resid	ence 6 Other	(Specify)
n 0	iding P th. After t funera	cate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigat	28a. Date of injury (Month, Day,		Time of 28c. Injury work M 1 □	/at ? Yes 2 □ No	28d. Describe h	ow injury occurred	d
.≥	il or Atter after dea Director: d in by the	Certificate:	2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 290 Blood of Injur	y - At home, f (Specify)	arm, street, factory, office	ies Z 🗆 iio	28f. Location (S City or Tow		or Rural Route Number,
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	only one) 3 Certifying N	miner: On the basis of ex	amination and	, death occurred at the time for investigation, in my opinional owledge, death occurred at t	n death occurred	at the time date a	nd place and due t	to the cause(s) and manner stated
	To t with To t		29b. Signature and title of certifier	All)	29c. License	number			(Month, Day, Year) 22012
			m/10/20 19/1/2	completed cause of de	ath (Item 23a)	(Time Diet)		attimor	e mo	21287
	Stat Registra		31. Date filed (Month, Day, Year)	32/ Registrar	's Signature	6.01			-	
DHM	IH 17 Rev 06-2		ULU U D.4			7.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ Month 2 Varian Medical Facility Name (if not institution, give street and number, **Examiner** County of Death eugu 6 Van auce. (In yrs. last birthday) ocial Security Number If Under 1 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Yrs 0171371921 **Director** 242-12-3076 NC Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Tes 2 X No Arno1d 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21012 934 Arundel Drive Late 125-0036

Learnit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: if item 27 is marked offer any injury or offer. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 No Specify. White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) W.R. Grace Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ethel Trull James Cooper Rickards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 934 Arundel Drive Arnold, MD 21012 Ronald Pease/Son in Law 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 12/03/2012 Glen Burnie,MD 4 Donation 5 Other (Specify) Atlantic Crematory Signature of Funeral Pervice Licensee 22. Name and Address of Facility 12 Ridgely Ave Annapolis, MD 21401 Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year sate has been signed by the spage 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed Yes 2 this certificate Be Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t 28d. Describe how injury occurred 1 Natural Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

2012

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Russell A. Keenapple November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie Birthplace (State or Foreign Country) If Under 1 8. Date of Birth . Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months (Month, Day, Year) 184-24-7709 84 Director 1 **X** M 2 □ F 10/21/1928 Scranton, PA Usual Residence of Deced 10c. City, Town or Location 10d. Inside City Limits 10a. State Director notified 28a-f MD Anne Arundel Odenton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō must be r Funeral 562 Williamsburg Lane 21113 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black White etc 1 Never Married 2 Married Ь þ 1 √ Yes 2 □ No If Yes, Give Korea Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: SpecifyWhite "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4 or 5+) Printing & Engraving 12 02 Bookbinder 77 is marked other traumatic event, the EENAPPLE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ٩ Florence Marsh Arthur R. Keenapple 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trait Vera W. Keenapple/Spouse 562 Williamsburg Lane Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place
Maryland Veterans 12/04/2012 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen 22. Name and Address of Facility Hardesty Funeral Home P.A.Gambrills, MD 21054 Tak 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 X No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation work? 1 ☐ Yes 2 ☐ No.

24 hours after deat Funeral Director: filled in by the completely within 2 the

IOXI State

Registrar

Medical

Accident

Suicide

4 Homicide

only one) 29b. Signature and title of certifie

29a. Certifie

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAREN CAMPBELL CRUP

Shaw Campbell CRIP

301 HOSPITAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R 118455

29c. License number

DR. Glen BURNIE, MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

11/29/12

29d. Date signed (Month, Day, Year)

41729

3. Time of Death

237 PM

1 Yes 2 X No

Year

31. Date filed (Month Day, Year) **DEC 0 4 2012** Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12-09360 Mary C. Keffer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lary C. Keffer	State of Maryland / Department	artment of He		, ,	201	2 4173
Physician Medical Examine	Decedent's Name (First, Middle,Last)	-		2. Date of Dear Month December		3. Time of Death 1358 hrs
	4a. Facility Name (if not institution, give street and number) 4407 Romlon Street Apt 2		y, Town, or Location of tsville		4c. County of De	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. I 225-76-3054 1 M 2XF 62	Mo	nder 1 Year If Under nths Days Hours		th(MM/DD/YYYY) 9. 5/1950	Birthplace (State or reign Country) Virginia
eath with the Maryland items 23s or 28s-f show any ast be notified at once.	MD Prince Coorsels F		Zip Code		Og. Citizen of What C	10d, Inside City Limits 1 Yes 2 X No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens (Mental Hygiens), or items 23a or 28a-f she Important. If them 71 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Einneral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Noivorced If Yes, Giva Year or Dates:	J.S. 13. Was Dece If Yes, spi 1 Yes	0705 Independent of Hispanic Original American, For the Communication of the Communication o	Puerto Rican, etc.)	White, etc	White
5-0036 ed within 72 hours tygiene. other than "natu		during most of	ual Occupation (Give kir working life. DO NOT us arketer	se retired)	16b. Kind of Busine Sale	
21215-0036 Juld be filed within 7 I Mental Hygiene. marked other than ic event, the Medica	John William Croy	19b. Mailing Addr		Name (First, Middle, Mane Phill er or Rural Route Num	ips	ate, Zip Code)
ges 1 and 2 sho t of Health and : If item 27 is other traumati	1 Burial 2 X Cremation 3 Removal from State	Place of Disposition (Note of	ce)	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr	4 Donation 5 Other Specify: At 21. Signature of Funeral Specify: MD 009	lantic Cre 22. Name a Thiba 7 Par	matory nd Address of Facility adeau Mortu rk Ave., Ga	12/15/2012 Lary Servic	e, P.A.	
Physician /Medical Examiner	Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Alcohol Due to (or as a consequence or condition)	. Do not enter the mod	le of dying, such as can	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence or c. Due to (or as a consequence or c.)					
0, be executed sician and burial - transit	3		ne,g934 12-	28-12 sm		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Ex		gnancy Fetal dea	th 3 Ectopic p	pregnancy	23d. Date of deliv	very Day Year
s, P.O. uires that the n signed by t Id be detache		esulting in the underly	ing cause given in Part	1 Yes	2 ✓ № 3 □ P	to the cause of death?
Vital Records, ystcian: The law require in sertificate has been significate, page 2 should be director, page 2 should be Completed					sy prior t	
/ital	25. Was case referred to medical examiner? 1 VYes 2 No Hospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (C		Residence 6 ✔ Ot	her: Scene
on of Vi cading Physi sath. or: After this the funeral di	27 Manner of Death	28b. Time of Injury fd: 1:50 pt	28c. Injury at Work?	28d. Describe h	now injury occurred	net. desire
Division o spital or Attending hours after death. neral Director: Aft filled in by the fune Certification:		ome, farm, street, facto	ory, office building, etc.	or Town, S Apt 2	tate)4407 Rom Beltsville	
To the Hos within 24 h To the Fur completely	Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in	my opinion, death occu			
	Cantorlead		O.C.M.E.		29d. Date signed (i	
-10	30. Name and address of person who completed cause of death (Item Laron Locke MD. Assistant Medical Examiner	•	re Street, Baltimo	ore, MD 21223		
State Registra		are backet		_		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rebecca Ann Knox Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Hagerstown Washington County 8. Date of Birth
July 13, 1958 Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Mary Land Hours 219-62-3958 Director Yrs permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "naturel", or items 23e or 28e-f show eny figury or other treumetic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Maryland Washington Co. Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 67 East Avenue USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clinic Asst. Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George H. Reisler Anne Mae Pomeroy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Douglas R. Knox / Husband 67 East Ave., Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Beaver Creek Cemetery 12-11-2012 | Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N. Hagerstown, MD Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical Examiner resulting in death) Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the Hospital or Attending Physicien: The law requires that the death certificate be executed ed by the ettending physician and detached for use es the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 NO 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed is funeral director, page 2 should be de Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 잍 1 Tinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 124 hours after death.

Je Funerel Director: Affeltely filled in by the fu Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hound to the second 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 151000

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene rois State Registrar Amend#1 per PHYS AMEND2**9Ertificate of Peath** 2. Date of Death 3. Time of Death Physician/ PM serald+ King 8:35 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Maryland of Baltimore City Media University If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) 390-30-7323 Director 76 1 ፟ M 2 □ F Yrs October 23, 1936 Wisconsin Usual Residence of Decedent th and Mantal Hygiana. 27 is marked other than "natural", or items 23a or 28a-fahow traumatic avant, the Moslical Examinet must be notified at 10b. County within 72 hours aftar daath with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Riverdale 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 4510 Sheridan Street 20737 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White If Yes, Give rres, Give Year or Dates. 1959—1961 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher 5+ Be ba filad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Royal W. King Ada C. Meitner 1 and 2 should to Haalth and Ma I Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yoko H. King / Wife 4510 Sheridan Street, Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Paga 1 a
Dapartmant of H
Important: If Ite
any injury or ott 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 12/5/2012 Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician Loukema disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Myelox Sequentially flet conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Aftar this cartificata has baan signad by tha attanding physician and funaral director, paga 2 should ba datachad for usa as tha burial-transit Hoapital or Attending Physician: The law requires that the death cartificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy 3 in the past 12 months? Month Day Year Other (specify) g Unknown 9 Unknown Division of Vital Records, P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? 1 Yes 2 No tha funaral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မှ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury To the Hoapital or Attending within 24 hours aftar daath.

To the Funaral Director: Aft complataly filled in by the fur work?
1 Yes 2 No Accident Investigation М 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 10 30,2012 1659670891 (IVA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St., Baltimore MD Bricker 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 15/01,5015, Sear 2:02 Рм CILE KELLY MATTIE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Mitchellville 10907 Spyglass Hill 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 257-90-6670 Director 1 🗆 M 2 🗶 F GA 04/15/1926 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland or items 23a or 28a-f sho miner must be notified at Director Mitchellville MD Prince Georges 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10907 Spyglass Hill 20721 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian. Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: Black "natural", 3 X Widowed 4 Divorced Completed the Medical Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Housewife ulth and Mental Hygie 27 is marked other in traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o ည Nellie Jackson Will Epps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10907 Spyglass Hill, Mitchellville, MD 20721 Teresa Johnson / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Veterans Cemetery 12/13/2012 Cheltenham, MD 4 Dopation 5 Other (Specify) 22. Name and Address of Facility Strickland Funeral Services Signatur Funeral 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part T. Enter the disease, or complications that course shock, or heart failure. List only one cause on each line enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition Physician/ lianant 1000 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examiner Due to for as a nonsequence of: Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last sician and burial-tran Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 👺 No Day detached for Month Year 9 Unknown 9 Unknown g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has I perform 1 ☐ Yes 2 No Yes 2X No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 St Other (Specify) home Hospital: Other: 2. X No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 X Natural Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and title of certifie 29d. Date sighed (Manth, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

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For MEND#10f per FH State of Many State 12/3/2012 AACO HEALIH DEPT. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Elizabeth Livingston HOYEMBER BAY 30 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deati AUTIMOREWISCHNICTON MENCALLE BURNIE ANHE wer GLEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Narch 3 1 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign Country) Director 259-36-8228 1 □ M 2 🛣 F 86 Yrs. 1926 Tennessee Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Crownsville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20- 21032 727 Old Herald Harbour Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian EUSABET Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: 3X Widowed 4 ☐ Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) 12th College (1-4 or 5+) Telephone Operator New York Bell Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Grover S. Humphrey Canarie Augustus JAINCATON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,2\,10\,3\,2$ Beverly Dorsey(Niece) 727 Old Herald Harbour Rd. Crownsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State Metro 4 Donation 5 Other (Specify) Crematory 12-3-12 Baltimore, Md. 21. Signature of Funeral Service Licensee Winname Recesse of SeciliSons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate EM PYSEMA Immediate Cause (Final Priysician/ disease or condition Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month cate has been signed by the spage 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No hin 24 hours after death.

the Funeral Director: After this certifica
mpletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 John M. Lawrence, Sr. Dec. 20:12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9522 Old Lantern Way Laurel Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) VA 8. Date of Birth **Funeral** Months Days Hours 03/28/1938 230 46 4787 74 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Howard Laurel 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral with 1 9522 Old Lantern Way 20723 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black "natural", 3 Widowed 4 Noivorced Completed Year or Dates ntal Hygiene. ced other than "natura c event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Auto Mechanic Exxon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve and Mental ဂ္ဂ Martha Holland George Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is Sherry Blue/ Daughter permit, Page 1 and 2: Department of Health Important: If item 27 any injury or other troonce. 9522 Old Lantern Way Laurel, MD 20723 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other placel 1 M Burial 2 Cremation 3 Removal from State Mt.Sinai Bapt.Cem 12/11/12 4 ☐ Donation 5 ☐ Other (Specify) Suffolk, VA 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityCroker Funeral Home educe 900 E. Washington St. Suffolk, VA 23434 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END RENAL DISEASE STAGE Ph_j i i n disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION YEARS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ó Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe EREBRAL VASCULAR 2 No 3 Probably 4 Unknown Completed 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2 No 2 Yes or Attending Physician: **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completed filled Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar ALITHA

29b. Signature and title of certifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D56797

DECEMBER 6, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 - For** State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O Pay 10:55 AM Richard Calvin LINN 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Julia Manior Healthcase Center Washington Haberstown . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 208-24-0543 1**X** M 2 □ F 79 Dec. 30 1932 Pennsylvania Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington 1X Yes 2 ☐ No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 923 W. Washington Street 21740 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 73 of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Teacher Tech. High School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Linn Jessie Fraker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Linn - Wife 923 W. Washington Street, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any Injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 12/11/2012 Hagerstown, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ a Atheroscleratio disease or conditi resulting in death) curciouasc war Medical Due to (or as a consequence of) Examiner Vascular Dementia with Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and I for use as the burial-transit Hyper tension

Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death the s P.0. been signed by t should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Seizure Disorder, Myocardia Records, 1 Yes 2 No 3 Probably 4 Unknown Completed InSarction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No : After this certifica e funeral director, l To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) R125360 12/10/2013

JN - 10 State

arbara Naden-Blucher, CRNP-333 Mill Street, Haverstown late filed (Month Perviet) 1 200 32. I gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Tow n/or Location of Death County of Death 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign -34-5 Months Days Hours Min. Director 1 □ M 2 X F 3 or items 23a or 28a-f show within 72 hours after death with the Maryland Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 101 eet and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White 9 1 Never Married 2 Married Yes Yes 2 Maryland 21215-0036 2 No "natural", 1 Yes Specify Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene. Moni Elementary/Secondary (0-12) College (1-4 or 5+) choo Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Lawrence (TEO) ar mant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number o Rural Royte Number, City or Baltimore, 0 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 200 City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one caus a on each line. Approximate Interval Between Immediate Cause (Final Oriset and Death Physician/ disease or condition Medical resulting in death) Du to (or as a consequence of) Examiner Sequentially list conditions, Examine Disk to for as a consectumour of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death Other (specify) Month Day Year the 9 Unknown 9 Unknown P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires Completed 2 No 3 Probably 4 Unknown 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 page, certificate 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After 28d. Describe how injury occurred 1 Natural
2 Accident work? 5 Pending injury death. 2 No within 24 hours after death

To the Funeral Director A
completely filled in by the Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R 23a) (Type, Print) of person who completed cause of de OFF US anti-cores 305 July 2015 M.A. (FYEEN USE)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ 41738 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month McGee Leonard Gene 4:30 2012 <u>December</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 33152 Shavox Road Wicomico Parsonsburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days Director 1 🛛 M 2 🗆 F 50 03/23/1962 Maryland Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene.
artment: If item 27 is marked other than "natural", or items 23a or 28a-f show fortur: If item 27 is marked other than "natural", or items 25a or 28a-f show injury or other traumatic event, the Maryland Evannine must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21849 33152 Shavox Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 K Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ambulance Service Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Claude McGee Dorothea LeBon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33152 Shavox Rd., Parsonsburg, MD 21849 Dorothea McGee/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/9/2012 Jerusalem Cemetery Parsonsburg, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licensee Dompoor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepoto Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) To the Hospital or Attending Physiolan: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: No No ၉ 1 Yes 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) D63199 12/6/12, GTC ress of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN SHURE SALISBURY, MD, VOHRA DR. 31. Date filed (Month,

DHMH 17 Rev 06-2011

State Registrar

32 Registrar's Signature

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3	Baltimore,	tof He If iten		20a. Method of Disp		3 Removal from	n State	20b. Pl	lace of Disperentery, cre	osition (Na matory or	ame of other plac	e)	C	Date	20c.	Location -	City or To	wn, State	
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		nysician/		Immediate Cause (disease or condition	(Final	nly one cause on ea	ach line.	2/1/1	linko	/	nuel	omo	2					Interval B Onset an	etween d Death
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Q.	. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death. To the Funeral Directors After this certificate has I seen signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use es the but	by Physician/Medica	23b. Was decedent in the past 12 1 Yes 2 5 9 Unknown	months?		Birth 2 I	☐ Fetal	death 3	Ctopic Other		ey				23d. Dat Mo	te of deliventh	ery Day	Year
3	P.O.	that the	by P	Part II. Other signif	ficant condition	ns contributing to d	death but	not resu	ulting in the	underlying	g cause giv	en in Part	t I.	23e. Did t	tobacco	use contr	ibute to th	ne cause of	death?
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7	E E	n: The ficate or, pag	ပိ	25. Was case referre	ad to madical									1 🗌 Yes	ormed?	No 1	Yes	2 🗆 No	
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C	0	ding Phys th. After this funeral di	te:	27. Mann of Deatl	h 5 🗆 Pendina	28a. Date			28b. Time o injury		28c. Injury work	at at		28d. Describe				HOD	picc
1	ion	Attending or death. ector: After by the fune	Certificate:	2 Accident 3 Suicide	Investig	ation				М	1 🗆	Yes 2	-						
354		To the Hospital or Attent within 24 hours after deat To the Funeral Director. completely filled in by the		4 Homicide	determi	build	ing, etc. (S	Specify)			•		J.	28f. Location (City or To	wn, Stat	te)			nber,
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		To the within 2 To the comple	~	30. Name and address 31. Date filed (Mont	title of certifier	w-She	uha	n	D.0	29	c. License	number H 6	8413	3	29d. D	ate signed	(Month,	Day, Year)	
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	Physicia		Decedent's Name (First, Middle, Las	it)					2. Date of Dea Month	10.00	Year	3. Time of Death
	Medic	al	Elaine M. McCı						11	28	2012	2300 M
)	Examin	er	4a. Facility Name (if not institution, give	street and number)	Mester	4b. City		Location of Death		4c. Cou	unty of Death	1100
	Funeral		5. Social Security Number 6. So		(In yrs. last birthda) If Und Months	er 1 Year	If Under 24 Mrs. Hours Min.	8. Date of Birt (Month, Day	h (Year)		place (State or Foreign
	Director		221-18-0131 Usual Residence of Decedent	□ M 2 □XF 81	Yrs.	Worth	Days	TIOUIS INIA.	1-7-19		MD	
	and show	ō	10a. State 10b. County		10c. City, Town or	Location		l			1	I0d. Inside City Limits
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	e filed within 72 hours after death with the Maryland ital Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evandher must be notified at	Funeral Director	10e. Street and Number				ip Code			10g. Citizen USA	of What Cour	ntry?
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ဖွ	or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X N		If Yes, sp	ecify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	etc.
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7	72 ho	Completed by	15. Decedent's E (Specify only highest gra	ade completed)	(Gi	cedent's Us e kind of w DO NOT u	ork done c	ation luring most of wor	king	16b. Kind	of Business/In	dustry
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Baltimore,	permit. Page 1 and 2 should be filed within 7/ Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, fire Ma once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dis	position (N	ame of		Date		ion - City or To	own, State
ţi	t. Page 1 tment of I rtant: If it		4 Donation 5 Other (Special	fy)	Mt. Zic	n Mi	ss C	em 12-8	-2012	Snow	Hill,	MD
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Box 68760	entifica Iding p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy				-	23d	i. Date of deliv	rerv
30X	leath o	icia	in the past 12 months?	4 Pregnant at	Petal death time of death	B ☐ Ectopie D Other (;y			Month	Day Year
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n of	ding P h. After t funera	ate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	Year) 28b. Time injur		28c. Injur work		28d. Describe h	ow injury oc	curred	
Division of Vital Records,	Atten	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	y - At home, farm,			163 2 1140			umber or Rura	l Route Number,
Ω	ital or irs afte ral Dir	<u>a</u>		building, etc.					City or Tow			
	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral prector darth. To the Funeral prector: The this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the tompletely filled in by the funeral director, page 2.	Medical	(Check 2 Medical Exam		amination and/or in	estigation, i	n my opinie	on, death occurred	at the time, date a	ind place, an	d due to the ca	ause(s) and manner stated.
	o the	Σ	only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practitioner: To the							igned (Month,	
			1836	MD			1	42995		11-29	9-201	2
	170		30. Name and address of person who	1.1.	ath (Item 23a) (Typ	e, Print)	(e number 42995 POWHE 1	1	11116	9-2012 NY M	10
		to-	31. Date filed (Month) Day, Year)	COLON M.	's Signature	7 a	er i	OINTE !	V. 5p	401504	114 111	
	Sta Registr		UEC 07 20	32. legistrar	A	bucke	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec. Day 2012 Richard Lynn McElwee 2:13a M 1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Howard County Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) 217-38-9673 Director 1 ፟M 2 □ F 72 June 11,1940 West Virginia Usual Residence of Decedent and Mental Hygiene.
I is marked other than "neture!", or items 23e or 28a-f show raumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits within 72 hours aftar daath with the Maryland Director SC North Myrtle Beach Horry 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4907 Stonegate Drive 29582 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XXI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည ě Warren McElwee Reita Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Pam Stevens/Daughter 3094 Greenhaven Court, Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 e
Department of I
Important: If ite
any injury or ot
once. 1 Burial 2 Scremation 3 Removal from State Metro Crematory Dec.3,2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) ettanding physician end for use as tha burial-transit Physicien: The law requires that the daeth cartificata be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day 1 Yes 2 9 Unknown signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physicien: The law requires within 24 hours aftar daath.

To the Funeral Director: After this certificets has been signompletely filled in by the funeral director, pega 2 should to 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NUS PIKE 2 No ဥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of certifie 29b. Signature 29c. License numbe 29d. Date signed (Month, Day, Year) 2012 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AARON 1 ST TONSON 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State UEU 0 4 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3715 5th Avenue Edgewater Anne Arundel 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 237-26-2485 **Director** 1 M 2 M 93 Yrs July 14,1919 North Carolina Usual Residence of Deceden 28a-f shov 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified et. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖾 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3715 5th Avenue 21037 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. φ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 US Postal Service Rural Postal Carrier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |William W. Hatley Addie Iola Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara G. Schnoor / Daughter 330 Arbutus Drive, Edgewater, Maryland 21037 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 a Department of H Important: If ite any injury or ot 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗋 Donation 5 🗀 Other (Specify) Hillcrest Memorial Cemetery 12-8-2012 Annapolis, Maryland 21. Signature Anneral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home all 2973 Solomons Island Rd., Edgewater, MD 21037 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Betw Immediate Cause (Final set and Peatb Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 24☐ No 25. Was case referred to medical examiner?

1 Yes 2 16 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) ᅆ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1/ Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3 12 ompleted cause of death (Item 28a) (Type, Print) 445 Annapolis 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 10, A^{M} December 6:30 Margaret Louise Myers Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min **Director** 217-95-7697 1 □ M 2 🕅 F 91 Sept 12, 1921 Usual Residence of Decedent Maryland 10b. County with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Williamsport 1X Yes 2 □ No Maryland Washington 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? be Funeral "natural", or items 23a dical Examiner must b U.S.A. 21795 205 Otho Holland Drive permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify. Completed White Health and Mental Hygiene. em 27 is marked other than "natu ther traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during rnost of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Supervisor Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Roger Ray Sinnisen Elenora Grace Easterday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troone. <u>Carla L. Kann</u>/ daughter 21740 333 Winding Oak Drive Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery 12/13/2012 | Hagerstown, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD Enter the disease, or complication or heart failure. List only one decins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1 Interval Between Immediate Cause (Final Onset and Death Physician/ ONSET JENTER CULAR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION HSTORY OF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown peen Were autopsy findings available prior to completion of cause of death? RECENT 24a. Was an PACEMAKER PLACENVEN page 2 has autopsy performed Yes 2 After this certificate 2 No Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 24 hours after deat Funeral Director: filled in by the

within 2 20 State

29b. Signature and title pf 29c. License number 29d. Date signed (Month, Day, Year) 53570C 510s 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWE NORTH ARTICAN ST. WILLIAMSDURT E IED legistrar's Signat

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Medical

29a. Certifier

(Check

only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death December 10 2012 1:24 Physician/ Рм William Emerson Murray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 800 Monroe Ave. Hagerstown Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Hours June^{h,} 9^{y,} 1928 Marvland 213-24-7502 84 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 800 Monroe Ave. 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. 0 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: "natural" Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Supervisor Food Distribution Co. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William F. Murray Bessie L. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rayetta Marie Murray-wife 800 Monroe Ave. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery | 12-14-2012 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final wee Physician/ CONS disease or condition resulting in death) Medical Due to (as a consequence of) Examiner Scumbally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death n signed by the a ld be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a, Was an il or Attending Physician; The law after death.

Director; After this certificate has b autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 2 No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 2012 Mdeath (Item 23a) (Type, Print) 30. Name and address of person who completed cause 13424 Pennsylvania Ave Suite 203 Hagerstown, MD 21742

Registrar DHMH 17 Rev 7/2009

State

Hatleberg, MD

strar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALEDA McCORMICK 10:00 PM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TIMONIUM STELLA MARIS HOSPICE HOUSE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 216-16-1449 Director 1 - M 2 - XF 11/18/1922 MARYLAND Usual Residence of Decedent 27 is marked other than "naturel", or items 23a or 28a-f shov traumatic event, the Medical Examirer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director YORK YORK 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1185 JUNIPER DRIVE 17408 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 Never Married 2 Married Black, White, etc. δ 1 ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: 3XX Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) SCHOOL SYSTEM CAFETERIA MANAGER æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE SCHATZ PEARL LAPOLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Depertment of Heelth ar Important: If Item 27 is any Injury or other trau once. ALICIA WALTERS/DAUGHTER 1185 JUNIPER DRIVE, YORK, PA 17408 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DEC. 10, HEDGESVILLE CEMETERY HEDGESVILLE, WV 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 21. Signature of Funeral Service Licenses 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate hes been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur completely filled in by the funeral director, page 2 should be detached for use as the bur 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 🕱 No 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 A Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

10:00 р.ш.

DECEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Lee O'Neal, Sr. 2012 8:07 Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5118 Smith Road Rohrersville Washington Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 216-38-0500 **Director** 1 X M 2 □ F 72 May 4, 1940 Maryland Usual Residence of Decedent 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 X No Maryland | Washington Rohrersville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5118 Smith Road 21779 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Operator II State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 0'Neal Ra1ph Marget Clemmie Homels 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther L. O'Neal/wife 5118 Smith Road Rohrersville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery 12/13/2012 Boonsboro, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityBast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of immediate Gause (Final aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events and -tran Due to (or as a consequence of) burial resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed page certificate 1 Yes 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 🗆 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending injury 1 Yes 2 No Accident the Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 11 2012 Alanna Jeannine Overdorff 3:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 17923 Garden View Rd. Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Nov. 8, 1931 181-24-8793 Pennsylvania 1 □ M 2 🛚 F 81 Director 28a-f show 10d. Inside City Limits 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17923 Garden View Rd. 21740 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 5 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify White If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene, item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Non Profit Organization Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Mary Deliah Burley Harry A. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traus 17923 Garden View Rd. Hagerstown, MD 21740 Gerald W. Overdorff-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 12-12-2012 Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease of complications that caus at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a on line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Day for Pregnant at time of death signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 page 2 funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 5 ☐ Residence 6 ☐ 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be after death Director: / filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause by death (Item 23a) (Type, Print) 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Prasek Thomas Wayne 1900 2012 December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WICOMICO ANCHORAGE NURSING/REHAB CENTER SALISBURY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days (Month, Day, Year) 152-34-7601 Director 1 X M 2 □ F 12/12/1944 New Jersey ed other than "natural", or Items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland Direct 1 ¥ Yes 2 ☐ No Maryland Salisbury Wicomico 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 105 Times Square 21801 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 X Yes 2 No Air If Yes, Give Year or Dates. Force 1 Never Married 2 Married Ś Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. Specify: White Completed 3 Widowed 4X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highe Airplane Maintenance end Mental Hygiene, Is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Inspection Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be fil of Health end Mental Item 27 Is marked မှ Matilda Gadzinski Larry Prasek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5404 Auth Rd, Suitland, MD 20746 David J. Prasek/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of Himportant: If Ite any Injury or ot Pege 1 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/7/2012 Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) il or Attending Physician: The law requires thet the death certificate be executed a after death.

Director: After this certificate hes been signed by the attending physician and After this certificate hes been signed by the attending physician and if funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2010 filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 \square Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours af To the Funeral D completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

12-09230 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Nancy Jane Panco State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner Month Day December 4, 2012 1304 hrs Nancy Jane Panco 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Route 275 and Craigtown Road Port Deposit Cecil If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Pennsyl vania 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Director Months Days Hours 193-30-9493 Aug. 4, 1939 73 1 M 2X F Country) Usual Residence of Decedent ıny 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 X No Marvland Cecil Conowingo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 976 Dr. Jack Road 21918 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces White, etc. Yes 2 X No White 3 Widowed If Yes, Give Year 1 Yes 2 No specify: 4 Divorced Specify: 2 or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Harford Duracool Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Twelve Years Havre de Grace, MD 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Harmon Thompson Gladys Craig Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) Robert Panco 21918 976 Dr. Jack Road, Conowingo, Maryland 20c. Location - City or Town, State West Chester 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Ferris & Co., Inc 12/07/12 R.A. 4 Donation 5 Other Specify: Pennsylvania Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, Maryland 21903-0766 Perryville. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. /Medical Between Onset and Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical g physician a UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery attending p 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Year 2 Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ₫ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed certificate has been a 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28b Time of Injury 28c. Injury at Work? Certification: Dec 4, 2012 car left road and overturned Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natural 1300 hrs 5 Pending 1 Yes 2 ✔ No 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) Route 275 and Craigtown Road, Port Deposit, MD determined (Specify) Major Road / Highway Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

OCME 2006

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

Zabiullah Ali, M.D.

31 Date filed (Month,

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item/23a)

Day, Year)

29d. Date signed (Month, Day, Year)

December 5, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Willie Robinson 3:45а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Wicomico 3782 Post Office Road Eden If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Min (Month, Day, Year) **™** M 2 □ F Director 428-56-2048 8-30-1930 Usual Residence of Deceden Mississippi 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Eden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3782 Post Office Road 21822 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. Army 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) John Williams Elementary/Secondary (0-12) College (1-4 or 5+) Bricklayer Construction Be permit. Page 1 end 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott eny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Curtis Robinson Mamie Crump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3782 Post Office Rd, Eden, MD 21822 Addie Robinson/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 12-10-2012 Hurlock, MD Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of) attending physician and for use as the bunal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month 1 Yes 2 9 Unknown page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hyper lipidemia autopsy performed? Yes 2 N or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0000132 MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

State Registrar Elleda Claire Ziemer

31. Date filed (Month, D

DHMH 17 Rev 06-2011

3. Registrar's Signatur

100 Power Street Salisbury,Md 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	1 - For State Registrar	otato or mary.	Cei	rtificate of E	Death	_ ,	Reg. N2 0	12	41/51
	Dhusisis		1. Decedent's Name (First, Middle, Las	ot)				2. Date of De Month	ath , Day	Year	3. Time of Death
	Physicia /Medic	al .	Radie Russo				L. Karad Davilla	Decem			1:25 PM
3	Examin	er	4a. Facility Name (If not institution, give Aurora Senior		Menatin	4b. City, Town, or	Λ	1	1	nty of Death 1 erse	+
, ARE	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th		lace (State or Foreign
	Director		221-20-1514	□ M 2 🗖 F	87 Yrs.	Months Days	Hours Min.	Nov. 16	, 1925		aware
7	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	cation				1	0d. Inside City Limits
	Maryl -f sho jed at	tor		omico	Salis	bury					1 ☐ Yes 2 🖾 No
-	or 28a s notif	Director	10e. Street and Number		-	10f. Zip Code			10g. Citizen o	of What Coul	ntry?
1	23a c ust be		6827 Lois Avenu			2180				S.A.	
1	er dea items ner m	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces? 1 ∐Yes 2 No	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No o Rican, etc.)	- 14. F	Race - Ameri Black, White,	
)36 1	Irs aft	by F	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🛣 No	Specify:		Spe	cify:	white
5-0036	illed within 72 hours after death with the Maryland Hygiene, Wher than "natural", or items 23a or 28a-f show ant, the Modified Evaminer must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occupa kind of work done d	ation Juring most of work	kina	16b. Kind of	Business/In	dustry
7	nthin ,	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	00 NOT use retired, memaker)			home	
7	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)		пс	memaker	18. Mother's Nam	ne (First, Middle	, Maiden Surn		
an	ental ental ked o ic eve	To Be	Gordy Toomey				Annie	Fisher			
Maryland	2 should be rand Mental Is marked or aumatic eve	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a					o Code)
	ges 1 and 2 should be filed it of Health and Mental Hygi if item 27 is marked other or other traumatic event, it		Yvonne Mariner	(Daughter)		Lois Ave	enue Sa	lisbury		21804	
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		Ob. Place of Dispo cemetery, crei	sition (Name of matory or other place		Date	20c. Locatio	,	,
altimore,	permit. Pag Department Important: I any injury o	}	4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer		arey's (Cemetery 2. Name and Addres)-2012	Mills	boro,	Delaware
n n	Depa Impo any i		21. Signature of Funeral Service Licer Shor	t-Jewis		Short Fu 13 E. Gr	ineral Ho cove Stre	ome eet De	lmar,	DE 1 <u>9</u>	940
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the cone cause on each line.	death. Do not en	ter the mode of dyin	g, such as cardiad	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	a		CVA				-	
	/Medical Examiner		Tooding in accumy	Due to (or as a cor	nsequence of):	ASLVD					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	b. Due to (or as a cor	nsequence of):	100 9					
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, 20,	icate be executed physician and the burial-transit	E	resulting in death) Last	Due to (or as a cor	nsequence of):						
09/89 09/89	runcate be executed ng physician and as the burial-transit	Medical		d							
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr	egnancy	☐ Ectopic pregnancy		*	23d.	Date of deliv	
n O	iaw requires that the death of as been signed by the attendion should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)	,			Month	Day Year
7. }	ires that the de signed by the a I be detached I		9 Unknown Part II. Other significant conditions	ontributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
Vital Records,	signe d be d	d by	Tak iii Gillor Gig	•·····••••••••••••••••••••••••••••••••		, 3		1 🗆	Yes 2 N	o 3∐ Pro	bably 4 🗆 Unknown
S	s been s	Completed						24a. Was		4b. Were aut	opsy findings available
Y F	Ine far ate has bage 2	Jwo							ormed?	death?	ompletion of cause of 2 □ No
Ita		Be C	25. Was case referred to medical examiner?				26. Place of Dea		one)		
6	this ald		1 ☐ Yes 2 ☐ No 27. Man/ver of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie		4 🗀 Nursing F	lome 5 ☐ Res			rify)
c 3	e e	tion	1 Natural 5 Pending 2 Accident investigatio	(Month, Day, Yea	ar) Injury	Work	yan k? Yes 2 □ No	200. 2000120	tion injury oo	danod	
Division	tal or Attending s after death. al Director: After ed in by the fune	Certification: To	3 Suicide 6 Could not b		At home, farm, st	reet, factory, office		28f. Location	(Street and No	umber or Ru	ral Route Number,
בֿ בֿ	tal or rs afte al Dir led in	Cert									
	Hospi 14 hou Funer Tely fil	ical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of my niner: On the basis of exa	y knowledge, dea ımination and/or i	th occurred at the tir nvestigation, in my o	me, date and plac opinion, death occi	e, and due to the urred at the time	e cause(s) and , date and pla	d manner as ice, and due	stated. to the cause(s)
-	Io the Hospital or, within 24 hours after To the Funeral Directory completely filled in the	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date si	gned (Month	ı, Day, Year)
	- s ⊢ ō		N.6			711	2094		12	16/12	
,	110		30. Name and address of person who		(Item 23a) (Type,	Print)	2 4	542(5.8)	0		63/1
(4,~		Vel NATESA~	32. Registrar's S		Hermon	Kel	54L (5.B)	, ry	M) 4	0 4
	Sta	te	31. Date filed (Month Day, 1) and 2	019 32 Registrars s	orginature .	and of					

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		State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death											
	Physicia	ın/	1. Decedent's Name (First, Middle, Las	Vane D.	Rich	hard 5		2. Date of Deatl	h Day - Y	3. Time of Death 2.50 P M			
	Medic Examin		4a. Facility Name (if not institution, give	1	/	4b. City, Town, or	Location of Death	Maranta	4c. County of				
and the second	Funeral		Social Security Number 6. Se	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birthplace (State or Foreign Country)			
	Director		579-28-6885 Usual Residence of Decedent	□м 2 🗓 F 86	Yrs.	Mionario Bayo	110010	12/7/1		Vashington, DC			
	ryland I-f shoried at	Director	10a. State 10b. County MD Carroll		, Town or Lor stmi ns					10d. Inside City Limits			
	the Ma or 28s	l Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	1 🔀 Yes 2 □ No at Country?			
	th with ms 23a must t	Funeral	239 St. Mark Way		1	21158		73	USA				
980	per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at announce.	ed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 2 No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		American Indian, White, etc. Thit e			
21215-0036	thin 72 hou ane. than "natu he Medical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4 or 5+)	(Give I life. D	dent's Usual Occupa kind of work done d O NOT use retired) h Tech	ation during most of worki			ness/Industry Pry County Schools			
Maryland 2	l be filed wi fental Hygid rked other tic event, ti	To Be (17. Father's Name (First, Middle, Last) Paul Arlington De	avis	TICALL	11 10011	18. Mother's Name Imogen I	e (First, Middle, M Eleanor	laiden Surname)	20110012			
, Mary	nd 2 should saith and N n 27 is ma er trauma'		19a. Informant's Name/Relationship (Ty Jim Richards/son										
Baltimore,	. Page 1 ar tment of He tant: If iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	ity or Town, State									
Ball	per lit Der art Imror any In		21. Signature of Funeral Service Licens	ee	1		ss of Facility Prid ington Roa			and Chapel MD 21157			
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	plications that caused the death				-		Approximate Interval Between			
.— F	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	of:	Sepsi	5			Onset and Death			
1	Examiner	<u>.</u>	Sequentially list conditions,	b.	leffice off.	Phermo	niz			Days			
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	e be executed ysician and ne burial-transit	g	that initiated events resulting in death) Last	Due to (or as a consequent d.	ence of):								
. Box 6876	Hospital or Attending Physician: The law requires that the death certificate by hours after death. Funeral Director, After this certificate has been signed by the attending physically filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnanc Other (specify)	÷у		23d. Date Monti				
ds, P.O.	v requires that the state of the signed by should be deta	ed by Pi	Part II. Other significant conditions co	ontributing to death but not resu			ven in Part I.			ute to the cause of death?			
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of V	ng Phys ter this ineral di	te: To	27. Mann of Death 1 Natural 5 Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	nt 3 □ DOA	4 ∐ Nursing Ho y at		nce 6 Other (w injury occurred	(Specify)			
Division	vttendir death. ctor: Af y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 ☐ No	20f Looption /Ctr	mat and Alimbar	Dy Dougl Dougle Mountage			
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		4 Homicide determined 29a. Certifier 1 Certifying Phys	building, etc. (Specify)		,	ļ	City or Town,	, State)	or Rural Route Number,			
	the Hos hin 24 h the Fun trpletely	Medical	(Check 2 L Medical Exami	ner: On the basis of examination be Practitioner: To the best of m	and/or invest	tigation, in my opinio	on, death occurred at	the time, date and	d place, and due to	the cause(s) and manner stated.			
			29b. Signature and title of certifier	An Mel	MD	29c. License	number 5059943	29	9d. Date signed (1	Month, Day, Year) 94/30/2012			
	10		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, P	Print) Ave	svite 3	67 INES	minsel	MD 21157			
	Stat		31. Date filed (Month, Day, Year)	32. Fegistrar's Signati	ure	247)	11 // /				

			Pleas	e Type or Pri							-		_	e.	
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	Physicia Medic	n/	1. Decedent's Name (First, Middle, L John Evan Ric	•							2. Date of De			5	3. Time of Death 10:27 PM
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			Carroll Hospice 5. Social Security Number 6		(In yrs. last birt	hdav)	If Under	mins	If Under	24 Hrs.	8. Date of Bird	th_			ace (State or Foreign
	Funeral Director	I 1	226-12-2236	1 X M 2 □ F	00	Yrs.	Months	Days	Hours	Min.	(Month, Da 02/19/	y, Year)		Country OH	
	т ом мо н		Usual Residence of Decedent		10c. City, Tow		antina				02/13/		,		d. Inside City Limits
	uryland a-f sh iied a	Director	10a. State 10b. County MD Carro	11	Westmi									10	1 X Yes 2 No
	he Ma or 28a notif	Dire	10e. Street and Number			-	10f. Zip	Code	_			10g. Ci	itizen of What	Count	y?
	with t	Funeral	300 St. Luke Cir	cle			Ĭ	2115	8			τ	JSA		
	death items		11. Marital Status	12. Was Decedent E Arroed Forces?	ver in U.S.		Was Deced	lent of Hi	spanic Or n, Mexica	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)		14. Race - Ai Black, W		
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Arroed Forces? d 1 X Yes 2 If Yes, Give Year or Dates.	No 1942 - 1946	-	1 🗌 Yes	2XI No	Specify	7.0				Whi	
9-0	hours natura lical E	Completed	15. Decedent	s Education			dent's Usua					16b. k	Kind of Busine	ss/Ind	ıstry
215	iin 72 ie. han "i	g .	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. D	kind of wor OO NOT use	rk done d retired)	uring mos	st of work	ng			1	
121	d with dygier ther t nt, th	اما	17. Father's Name (First, Middle, La.	2		pt.	<u>ician</u>		10 Moth	or's Nom	e (First, Middle,		lf-emp	голе	<u> </u>
and	be file ental H ked o ic eve	흔	Edgar Evan Richa	•							Lewis	Maiden	Garriarro		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Jim Richards/son	(Type, Print)	198	5. Maili	ng Address	(Street a	and Numb	er or Rura	Route Numbe	r, City o	r Town, State,	Zip Co 177	nde)
ē,	f Heali item 2		20a. Method of Disposition		20b. Place o	f Disp	osition (Nar	ne of			Date	20c. L	ocation - City	or Tov	n, State
m0	Page nent o int: If iry or		1 Burial Cremation 3		Carro	-	matory or o	_		12/1	/2012	Han	npstead	l, N	D
Salti	Departn Departn Importa any inju		21. Signature of Funeral Service Lic	ensee							Funera				_
ш	20 E 20 0				10 - 1 - 0 - 5 -						d, West		ster, M		21157
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limburged the cause (Final disease or condition)												Approximate Interval Between Onset and Death
	Ph, it is a Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	_	I VE		h 1,1					1	
	Examiner	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
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	e executed sian and rurial-transit	Exar	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):	-							+	
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68760	death certificate be ne attending physici ed for use as the bu	Physician/Medic	IF FEMALE:												
Box 6	tth cer ttendi for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal deal		Cotopic Other (s		СУ			1	23d. Date of Month		y Day Year
	y the a	hysic	1 Yes 2 No 9 Unknown	9 Unknown	time of death	<u> </u>	_ Other (s)								
P.O.	requires that the death certificate be exbeen signed by the attending physician should be detached for use as the buria		Park Other significant condition		out not resulting				ven in Par	t I.					e cause of death?
rds	equire een si hould	eted	LENTEDE X		ENO		ίΟ.				24a, Was				sy findings available
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Completed by	severe he	1211C 71	CPO	/ (\					auto	psy ormed?	prior deat	to con	ppletion of cause of
tal	ysician: T is certifica director, p	Be C	25. Was case referred to medical examiner?	Hospital:							k only one)				140 04 11 11
Ţ	Physi this c	은	1 Yes 2 No 27. Manner of Death	1 Inpati	ient 2 ER/C	utpatie		Oth 28c. Injur	4 🗆 1	Nursing H	ome 5 Res			pecify)	HCCDIC
0 U	nding ath. : After e fune	icate	1 Natural 5 Pending 2 Accident Investig	(Month, Da	y, Year)	injury	М	worl		□No	200. 2000/100	now inju	,, , , , , , , , , , , , , , , , , , ,		rustice
isic	r Atte ter dea rector	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ury - At home, f c. (Specify)	arm, st	treet, factor	y, office			28f. Location City or To			Rural	Route Number,
ğ	oital o		On One Service of Constitution	Physician: To the best of		طه مهاد		t the tim	o doto or	d place o	and due to the	cauca(c)	and manner s	e etate	d
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Medical	(Check / 2 Medical Ex	caminer: On the basis of a Nurse Practitioner: To the	examination and	or inve	stigation, in	my opini	on, death	occurred a	t the time, date	and place	ce, and due to	the cau	se(s) and manner stated
	To the within To the comp	2	29b. Signature and title of certifier	1/2 000	>				e number	30			ate signed (M		_
	BC.		30 Name and address of person w	Malcompleted cause of	teath (Item 22a)	(Type	Print\	リラ	K 72	18		11	- 3C) —	16
/(0+1VA		Flavio Krutur	MD 555	ar's Signature	lh.	Cent	er:	<u>Sł.</u>	Wea	runte	ste	v, m	D	21157
	Sta Registr		31. Date filed (Month, Day, Year)	2012 Line	a s Signature	19	ak	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 7°,2012 Year 6:00 PM Physician/ Ronald Lee ROSS December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown 1067 Lindsay Lane If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) **Funeral** Months July 31, 1947 New York 65 **Director** 069-38-3501 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10a. State Director Hagerstown Maryland Washington 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or dical Examiner must be r 21742 Funeral 1067 Lindsay Lane U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 white 1 Yes 2X No Specify. Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) College teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) ೨ Nat Ross Evelyn Montagne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth an Important: If item 27 is any injury or other trau 18929 Orchard Terrace Road, Hagerstown, MD 21742 Catherine Ashley Cotleur - Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 K Cremation 3 Removal from State Hagerstown Crematory 12/10/2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Minnich Funeral Home Signature Funeral Service Lic 415 East Wilson Blvd., Hagerstown, Maryland 21740 len Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner aldra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last executed and -tran Due to (or as a consequence of): burial physician s the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death s been signed by tach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 X No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one are and title of certifie 29h. Sign 29c. License number 29d. Date signed (Month, Day, Year) ARDIOLOG 157 12/10/12

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOOG4 22

11110 Medical Campus Rd Hagerstown Mounts

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret Ann Regan 4:58 PM Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Funeral 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign New Jersev Director 143-22-9876 1 M 2XXF 81 March 10,1931 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d Inside City Limits Director Maryland Washington Co. Magansville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13941 Distant View Avenue 21767 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit, Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any Injury or other traumatic event 4 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Adamcik John Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Regan/ Son 13941 Distant View Ave. Maugansville. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Smithsburg Crematory Dec. 9,2012 Smithsburg, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final CORDNARY ARTTRY Onset and Death Physician/ DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of): Éxaminer TY POXE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of: FIBRILATION Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician a detached for use as the burial Physician/Medical METABOLIC Aci DOSIS Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Yes 2 No 9 Unknown 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: After this certifice etely filled in by the funeral director, p 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne Death Certificate: 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier To the Hospi within 24 hou To the Funer completely fil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, duality consists of the time, date and place, and due to the cause(s) and trainer as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MOHA MMFB ALIZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11116 Medical Campus R State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. Physician/ Llewellyn Ernest Rose ฉอใจ็ 1:170 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital emorial Easton Talbot If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 1 XM 2 □ F 007-16-5204 87 Feb. 24,1925 North Leeds, Maine item 27 is marked other then "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director Caroline Maryland 1 🗆 Yes 2 🖾 No Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12669 Greensboro Road 21639 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Cartographer Federal Gov. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If Item 27 is marked of any injury or other traumatic eve ည Harold Rose Goldie Gould 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Parker Rose (Wife) 12669 Greensboro Rd., Greensboro, MD, 21639 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Rose 1 X Burial 2 Cremation 3 Removal from State 12/03/2012 Greensboro, Maryland 4 Donation 5 Other (Specify) Greensboro Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ${ t Fleegle\&Helfenbein Fun. Hm.}$ 21639 106 West Sunset Ave., Greensboro, MD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): within 24 hours after death,

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No a 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗆 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,

Ne GX

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, NOV 3

Print)

cause of death (Item 23a) (Type,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Vear Donald Brent Spicer 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HICOMICO MODILIAL CENTU KIGIDNAL 3AL136U1 TENINSULA If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) Director 221-58-6653 1 🔀 M 2 🗆 F 40 July 8, 1972 Delaware Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Mardela Springs 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 502 Charles Street 21837 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1994-1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 ☐ Widowed 4 M Divorced Specify white Completed 1998 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 technician pest control Be Page 1 and 2 should be filed in ment of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Donald Lee Spicer Nancy Shockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21837 Charles Street Mardela Springs, MD <u>Nancy Abbott</u> (Mother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore Vet. Cem.12-7-2012 Hurlock, Maryland of Fun Service License 22. Name and Address of Facility Short Funeral Home È will 19940 13 East Grove Street Delmar, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease, or co-shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final ESPIVATOR Priysician/ disease or condition Medical resulting in death) Éxamine etastases ulmonary Sequentially list conditions, if any hadding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine horiocarcinoma 45 or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 as the IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed?

1 Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o မြ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral directors. 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical (29a. Certifier 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature d title of certifier

Registrar

State

31. Date filed (Monto)

VA

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 5:45p Helen Inez Shafer Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil 99 Slicers Mill Rd. Rising Sun Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours **Director** 1 □ M 2 🙀 F 219-32-2688 78 Yrs. 7/22/1934 TN Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits notified at Director 1 Yes 2 No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be items 23a Funeral 99 Slicers Mill Rd. 21911 USA · death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. 0 ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White "natural", 3X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked ot
traumatic ever 2 Martha Jane DePew Tyler Seal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other traumonce. MD 21911 Linda Pierce/ daughter 99 Slicers Mill Rd. Rising Sun, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date atory or other place) 11/17/ Baptist Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Rising Sun, MD R.T. Foard Funeral Home, P.A. 111 S. Queen St. Rising Sun. MD 000 Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PARKINSONS DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of Examiner CHRONIC OBSTRUCTIVE LUNG DISCOM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine executed DEMENTIA and burial-tran Due to (or as a consequence of) resulting in death) Last nding physiciar. Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at 1 be detached for 9 Unknowi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident 24 hours after death. Funeral Director: A Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

Hospital or Attending Physician: within 2 **To the F**

> 10 State Registrar

completely

29a. Certifier

29b. Signature and title of certifier

P.V. Naye N.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAD NARAYANA V. PULA , 126 A. EAST 31. Date filed (Month, Da

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DOO 65 733

smeet.

MGH

29d. Date signed (Month, Day, Year)

ELKTON HD 21921

12/11/12

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 4:05 a M 2012 Michael Allen Sherrod Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perryville Cecil 310 Mansion Drive, Apt. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 230-78-7843 **Director** 1 🛛 M 2 □ F 60 Oct. 18,1952 Maryland Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Exeminer must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Perryville 1 X Yes 2 No Cecil Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 310 Mansion Drive, Apt. No. 6 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ۾ Maryland 21215-0036 1 Yes 2 No Specify: Yes. Give Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry
Seaboard Foundations 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Woodstock, Virginia Master Crane Mechanic Twelve Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rose Marie Casper James Sherrod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 631 Corapeake Drive, Chesapeake, VA 23322 James MacAlloon (Executor) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location, City or Town, State West Chester. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. 12/07/12 Pennsylvania 21. Signature of Funeral Service Licer Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ olid らくろん disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami To the Hospital or Attending Physician: Tha law raquinas that tha death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has baen signed by the attending physician and complately filled in by tha funeral diractor, paga 2 should be datachad for usa as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home ည 1 🗌 Yes No 🗓 🖍 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifie 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 13 31. Date filed (Mo 32. Pegistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Decedent's Name (First, Middle, Last)
Earl Daniel Shickman 2. Date of Death November Physician/ 2012 8:31 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County 961 Firestone Road Westminster 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. 8 1 🛛 M 2 🗆 F Months Days Hours Min. Mary Tand 212-70-4571 57 1955 Director Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland in the 27 is marked other than "natural", or items 23a or 28a-f shoring or other traumatic event, the Medical Examiner must be notified at 10a, State Director Maryland Carroll County Westminster 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 961 Firestone Road 21158 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Was Decedo...
Armed Forces?

1 Yes 2 1986-11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 1986 Year or Dates. 1991 white Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) baker bakery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester Nottingham Shickman ဂ္ Mary Delores Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 961 Firestone Road Westminster, Maryland 21158 Mary D. Shickman / mother Baltimore, Nov. 2012 20a. Method of Disposition 20b. Place of Disposition (Name of Date 30, 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State carroll Cremation Hampstead, Maryland 4 Donation 5 Other (Specify) Eline Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service License M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ OITIETO Medical Due to (or so consequence of): Examiner 4000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of: or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death s been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I page 2 autopsy performed?
1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: မ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work' 5 Pending 1 Tes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

VA

31. Date filed (Month, Day, Year)

MNV 3 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012

12301

LOCKST L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day O J Physician/ DISCON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis 108 Green Spring Drive 8. Date of Birth
(Month, Day, Year)
Aug. 15, 1920 Social Security Number 217–46–2566 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 92 Months Davs Country) Maryland Director 1 M 2 M Yrs or then "neture!", or itams 23e or 28e-f ehow the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Annapolis Anne Arundel 1 Yes 2XXNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21403 108 Green Spring Drive Funeral 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. i Hygiena. other then "neturei", or ģ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify If Yes, Give Year or Dates. WW II Completed **ॐ**Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ETROSINI DIAMONGICIS should be file and Mantel F is merked of Nicholas Bounelis 19a. Informant's Name/Relationship (Type, Print)
Laura Downie/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 5976 Dana Drive Norcross, Georgia 30093 permit, Paga 1 and 2 sh Department of Heaith ar Importent: If itam 27 is any injury or othar treu Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Baltimore Crematory 12/4/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 Musel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final Physician/ RRHOSI disease or condition resulting in death) Medical Due to (or as a consequence of) [/]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the buriai-transi thet the deeth certificate be axecuted that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy 1 ☐ Yes 2 ☐ No 1 Yes 2 N Hospitai or Attending Physicien: Division of Vital funerel director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death, unerai Diractor: Aft ely filled in by the fur 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 100 103 30. Name and address of person who completed cause of death (Item 231) (Type, Print) 5 Defense Highway Annapolis, MID 31. Date filed (Month, Day, Year) State DEC 0 4 2012 Registrar

DHMH 17 Rev 06-2011

12-09220 Jerome Darick Sw	/an 1	n - For State Ame		or Print in Bl of Maryland per OCME						Hygiene		0.1.0	11766	
Physician Medical Examine	n/ er	1. Decedent's Nam	e (First, Middle,La		ME DE		K SWAN	N	ocation of Dea	2. Date of Dea Month Decembe	Day Y r 4, 2012	ear Posth	3. Time of Death 0407 hrs	
Funeral	ı		House Rd. &	Old Pike Way	je (In yrs. Ia	ast birthda	Uppo y) If Uni	er Marlbo der 1 Year	oro If Under 24Hi	rs. 8. Date of Bir	Prince		hplace (State or	
Director	- 1-	213-17-5 Usual Residence of		X M 2□F	25	Town or L	Yrs.	ths Days	Hours Mi	09/13	/1987	cal	10d. Inside City Limits	
≱	ector	MD 10e. Street and Nu	ST. MARY'	S	MEX	HANIC	SVILLE 10f. Zi	ip Code	<u> </u>	1	0g. Citizen of 1	What Coun	1 Yes 2 X No	
er death with the Maryland or items 23s or 28s-f sho must be notified at once.		40416 BA 11. Marital Status 1 X Never Marri		12. Was Decedent	?	S. 13		dent of Hispa	659 anic Origin? (\$ Mexican, Puerl	Specify Yes or No)- 14. Ra	ITED STATES 14. Race - American Indian, Black, White, etc.		
nours after de natural?, or i	함.	3 Widowed 15. Decedent's E	4 Divorce	d If Yes, Give Year or Dates: only highest grade cor			edent's Usua		specify: in (Give kind of DO NOT use re		Specify	y: BLAC		
5-0036 ed within 72 l sygiene. other than "1	Completed	Elementary/Sec 12 17. Father's Name	, ,	College (1-4 or	5+)		UNDMEN	& LA	BORER	•	CONST		ON	
Should be file and Mental H	GROUNDMEN & LABORER CONSTRUCT 17. Father's Name (First, Middle, Last) ALLEN SWANN 18. Mother's Name (First, Middle, Maiden Surname) ALLEN SWANN 19a. Informant's Name/Relationship (Type, Print) MARY SWANN/MOTHER 40416 BAY DRIVE, MECHANICSVILLE, MD 2													
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)									etery,	Date 20c. Location - City or Town, State 20/2012 WALLORF, MARYLAND				
	04	21. Signature of Fu	HORNION JO	HNSON/M00583			22. Name an THORN 3439	d Address of LON FI	Facility INFRAL	HOME IND	ran hea	D, MI	20640	
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):										теат	Approximate Interval Between Onset and Death	
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Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Etapital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Fanaral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burified of the fate of the funeral director, page 2 should be detached for use as the burified.	/sician/me	IF FEMALE: 3b. Was decedent past 12 months	\$?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown		2	Fetal death		Ectopic pregr	nancy	23d. Date Month	of delivery D	ay Year	
aw requires that the de last been signed by the 2 should be detached for the December 1000 for the property of the last been stated for the last beautified.	6	Part II. Other sign	ificant conditions		h but not re	sulting in	the underlyin	ng cause giv	ren in Part I.	1 Yes	s 2 🗸 No	3 Prob	he cause of death?	
tal Record cian: The law req certificate has bee	24a. Was an autopsy findings performed? 1 ✓ Yes 2 ◯ No 1 ✓ Yes 2 ◯										ompletion of cause of			
f Vital Physician: or this certification,	ן מ	25. Was case refer examiner? 1 ✓ Yes		Hospital: 1 Inpatio	ent 2	ER/Outpa	itient 3		of Death (Check ther 4 Nurs		Residence 6	Other:	Scene	
27. Manner of Death 1									in motor ve	hicle col				
Accident Successful Succe										d.				
To the Hos within 24 h To the Far completely	Medic	one) 2 🗹 29b. Signature and	title of certifier	and manner stated.		nd/or inves		9c. License	number	at the time, date	29d. Date si	gned (Mon	th, Day, Year)	
80,8		30. Name and addr	ess of person who	completed cause of casts ant Medical F	death (Item		N Baltim	O.C.M		MD 21222	Decembe	er 4, 201		
Stat	Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registrar Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223													

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elsie Louise Sandidge 20^{Year}2 Dec. 5:56 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 577 42 0303 1 M 2 DXF 82 5/14/1930 DC Usual Residence of Decedent th end Mental Hygiene. 27 is marked other then "natural", or Items 23e or 28e-f show traumetic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Prince George's Temple Hills 1 TxYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3410 Orme Drive 20748 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health end Mental trant: If Item 27 is marked (sjury or other traumetic even) ည Robert Swann Carrie Tinker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrington Sandidge/Hus. 3410 Orme Drive Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If Ite eny Injury or of once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran Cem. 12/13/12 Cheltenham, MD 21. Signature of Funeral Service License 22. Name and Address of FacilityBriscoe-Tonic Funeral Home Kimberly 2294 Old Washington Rd.Waldorf, MD 20601 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Atherscherotic Immediate Cause (Final 01000 Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence or; ettending physician and for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) Month Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဨ 1 🗌 Yes 2 🗆 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Hornicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rny opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of rny knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D64055 2/06/17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McDonald Eric 7503 Surratts Road Clinton, MD 20735 31 Date filed (Month. Registrar's Signatu State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_	Pleas	e Type or Pr State of M					All Copie I Mental Hy		Legible	•
	•	For State Registrar					tificate of			Reg. No.	2012	41764
Physicia Medic		1. Decedent's Name (Delores	First, Middle, L	E.	S	Sunder]	and		2. Date of De Month	oath 07	2012	3. Time of Death
Examin	-	4a. Facility Name (if no	, ,	ive street and number)	\		1 1	or Location of Dec			County of Deal	
Funeral		5. Social Security Nun		Sex 7. A		ast birthday)	If Under 1 Year Months Days	If Under 24 Hi	s. 8. Date of Bir	th	g. Bir	tholece (State or Foreign untry)
Director		214-46-55 Usual Residence of D		1 □ M 2 🌣 F	6	5 Yrs.	Worths Days	Hours		23, 1	947 Me	aryland
/land f show ed at	tor		10b. County		10c. City	y, Town or Lo	eation					10d. Inside City Limits
e Man r 28a- notifie	Funeral Director	Maryland 10e. Street and Numb	Washin	gton	На	gersto	wn 10f. Zip Code			10a Citi	izen of What Co	1 🔀 Yes 2 🗌 No
with th	eral	14014 Mar		Δ			21742				S.A.	ountry ?
items		11. Marital Status	. SII IIR	12. Was Decedent Armed Forces			Vas Decedent of		Specify Yes or No-		14. Race - Ame Black, Whit	
al", or	d by	1 ☐ Never Married 3 ☐ Widowed 4		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.			☐ Yes 2 🔀 N		, , , , , , , , , , , , , , , , , , , ,		0	hite
Phours "natur dical B	Completed		15. Decedent's				lent's Usual Occu	pation during most of w	orkina	16b. Ki	nd of Business	Industry
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illed will Hygid I other	Be	17. Father's Name (Fir	rst, Middle, Las	t)				18. Mother's N	lame (First, Middle,			
Ild be f Menta iarked atic e	P P	Thurman	Charles	s Baker				Delor	es V. Ke	nnedy	7	
2 shouth and the and the strain traum		19a. Informant's Nam		(Type, Print) and / Husba	and				Rural Route Numbe			
1 and of Heal item		20a. Method of Dispos	sition		20b. P	lace of Dispo	sition (Name of natory or other pla		Hagersto ^{Date}		cation - City or	
ment crant trant:		1 X Burial 2 □ 4 □ Donation 5		☐ Removal from Statecify)	0	st Have	en Cemet	ery 12	/11/12			, Maryland
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune	ral Service Lio	ensee					est Have Ave., H			
•		23a. Part 1. Enter the	disease, or co	hplications that cause y one cause on each li	ed the deatl							Approximate Interval Between
Physician/		Immediate Cause (Findisease or condition		Co	ona	14 8	Artein	Dio	ease			Onset and Death
Medical Examiner		resulting in death)		Due to (or as		ience of): CNS10						
	iner	Sequentially list cond if any, leading to immo cause. Enter Underly	nediate 🔝	b. Due to (or as	a consequ	ience of):		7				
be executed sician and burial-transit	Examiner	Cause (Disease or iin that initiated events resulting in death) La	njury	c. Due to (or as), abc-	, ,	Iclitus	Type II				
sician burial	cal	resulting in death) Ea		d	- a conces							
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eath certificate b attending physic I for use as the b	cian/	23b. Was decedent pr in the past 12 mg	onths?	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 Feta	ıl death 3 🗆	Ectopic pregnar Other (specify)	псу		:	23d. Date of de Month	livery Day Year
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requires that the de been signed by the should be detached	Completed by Physician/Medi	Part II. Other signific	ant conditions	s contributing to death	but not res	ulting in the u	nderlying cause g	jiven in Part I.				o the cause of death? Probably 4 🔀 Unknown
require been s should	leted								24a. Was			itopsy findings available
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cian: T ertifica ector, p	Be C	25. Was case referred examiner?	to medical	11				Place of Death (C/		2 110	1 10 10	3 2 3 110
Physion this of ral direction	2	1 Yes 2 X	No	Hospital: 1 Inpa		ER/Outpatier	it 3 DOA Ot		Home 5 Resi			oify)
arth. rr: After ne fune	icate	1 📉 Natural 2 🔲 Accident	5 Pending Investigat	(Month, D		injury	wo		Zod. Describe	10 W IIIJul y	Occurred	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 U Could no determine	28e. Place of Ir	ijury - At ho tc. <i>(Sp</i> ec <i>ify</i>		eet, factory, office		28f. Location (City or Tox	Street and vn, State)	l Number or Ru	ıral Route Number,
spital hours a neral C		29a. Certifier 1	Certifying P	h ysician : To the best o	of my knowi	edge, death o	occured at the tim	e, date and place	, and due to the ca	use(s) an	d manner as st	ated.
the Ho nin 24 the Fu nplete	Medical	only one) 3	Certifying N	miner: On the basis of urse Practioner: To th						ne cause(s) and manner as	
To To Coor		29b. Signature and tit	le of certifier	\cap	Λ	CRI	29c. Licen	se number	7	29d. Dat	e signed (Mont	h, Day, Year)
i		30. Name and addres	s of person wh	o completed cause of	death (Item	23a) (Type, F	Print)	19	01.	104	1110	
4-4		Stephan	Il Con	KI-Congo	rdia	CRUP	14014	Marsh	Pike	1-100	e15 +0	oun 21742
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Superka Cyri1 2012 5:03 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1176 Luther Drive Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Min Director 200-10-1148 1 🕅 M 2 🗆 F 93 Aug 22, 1919 Pennsylvania show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 X Yes 2 □ No Maryland Washington Hagerstown 10f. Zip Code ò 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral 1176 Luther Drive 21740 USA "natural", or items dical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 and 2 should be filed within 72 hours after ו זי Health and Mental Hygiene. item 27 is marked other than "האזוויים" יי 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates. White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Joseph Charles Superka Anna Pauline Polchik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Weitzel/daughter 20490 Casablance Drive Ashburn, VA 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro Cemetery 12/14/2012 Boonsboro, Maryland 21. Sign ture of Fun ral Surv e Licen 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part 1. shock Approximate Immediate Cause (Final Onset and De th Physician. OVONOVY disease or condition march Medical resulting in death) Due to (or as a consequence of): Examiner Securitally liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law certificate has performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital: Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify, To the Hospital or Attending Phys within 24 hours after death.

Jo the Funeral Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ompletely filled in by determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

s Street Heigenstone

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RR.

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M AR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shumaker 6:20 P M Dona1d Lee 2012 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington 101 Kerns Drive Boonsboro 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours 214-34-2494 Director 1 X M 2 □ F 74 May 9**,** 1938 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No <u>Maryland | Washington</u> Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Kerns Drive <u> 21713</u> USA "natural", or items edical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 2 No 1956-1 Never Married 2 X Married 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced 1964 Year or Dates. White and 2 should be filed within 72 hour Health and Mental Hygiene. tem 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Machinist Manufacturing Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Florence L. Long W. Shumaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blanche E. Shumaker/wife 101 Kerns Drive Boonsboro, Maryland item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/14/2012 Boonsboro, Maryland Boonsboro Cemetery 21. Signature of Funeral Service Lichard 22. Name and Address of FacilityBast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD r ter the disease, or complicators the r heart failure. List only one contents caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. 23a. Part 1. shock Approximate Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ó Day Year the a 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mabelise mellitus 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Hypertensim 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 N 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of To the Hospital or Attending F within 24 hours after death.

The Funeral Director: After 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) sompletely filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)
December 12, 20/2 29b. Signatul D44996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 Cappans & Bomishin Ma 217/3

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

11:15 A M

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between nset and Death

Day

1 Tes

12916 Corana Dr. Suite ZOY Hazershuss MD

1 🗆 Yes 2 🔀 No

Maryland

White

Registrar DHMH 17 Rev 7/2009

State

Jenniter

Janu

dress of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Gilbert Roosevelt SHUMAKER, Jr. OI Z Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Months Hours 219-74-3795 Director 1 X M 2 | F 53 March 14,1959 Maryland in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Washington 1 ☐ Yes 2X No Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10913 Rosewood Drive 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Š 1 ☑ Never Married 2 ☐ Married ☐ Yes 2 🛣 No Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced white Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 I h and Mental Hygiene. **7 is marked other than "r** (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) none none Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gilbert R. Shumaker, Sr. Thelma Madaline Eavey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Thelma Nicodemus - mother 10913 Rosewood Dr., Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If its any injury or of 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem.Park 12/14/12 Hagerstown, Maryland 21. Signa un of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on wich line. Immediate Cause (Final Pret and Debth Physician disease or condition Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the use as attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Live Berth 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) been signed by the s should be detached g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2 N **Division of Vital** by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🗹 No Other: 잍 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined filled in t City or Town, State) 24 hours a Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basic-of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MDU052136 of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day

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Division of Vital Records, P.O.	after after Direct din by	Se	4 U Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, tarm, stre	et, factory, office		28f. Location (St City or Town	reet and Nu n, State)	mber or Rural I	Route Number,	
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	37C		30. Name and address of person who con	mpleted cause of death (Item 2	23a) (Type, Pr	int) MU 1L	everyn !	Doad	CA	A . A	113 310-	
	Stat	e	31. Date filed (Morth, Day Year)	2. Registrar's Signatu	ire	7917 47	i - myse	vas	YTUSI	BUM	MO 470	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David A. Tuttle December 2012 12:05 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County E1kton Ceci1 Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) April 15,1947 1 🛛 M 2 🗆 Months Days Hours Min California Director 555-70-9601 65 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Maryland Cecil Port Deposit 10e. Street and Number 10g. Citizen of What Country? Funeral 1834 Frenchtown Road 21904 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2XXMarried 1 Yes If Yes, Give 2 **X X** Vo 1 Yes 2XXNo Specify: 3 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 ed other tevent, th Self Employed Trucker Trucking Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed.
Department of Health and Mental Hilmportant: If item 27 is marked ott any injury or other traumatic even မ Edward David Tuttle Emma Wojatski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Tuttle / Spouse 1834 Frenchtown Road, Port Deposit, Maryland 21904 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 11, 2012 Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death? performe Yes 2 N 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Other: 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death nours after death.

neral Director: After the filled in by the funera 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062190 8/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN MD

State Registrar AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKE CITY, MD 21915

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 12/02/2012 MADELINE JOYCE TIMBERS 2304 М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours **Director** 579-34-5451 1 □ M 2X F 01/24/1925 87 MD r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard Columbia MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7110 Minstrel Way 21045 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Š 1 ☐ Yes 2 ☐XNo If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Worker Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Brown James A. Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5523 Etta Court, Columbia, MD 21045 Debbie Davis/niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Memorial Pk 12/10/2012 Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiac Arrthymia Instant Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physiclan: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24 hours after death.

• Funeral Director: After this certificate has been signe etely filled in by the funeral director, page 2 should be etely filled. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Hypertension Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work? 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hound To the Funer completely file 29a. Certifie + [X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. All Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number D28656 2/3/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD. Shady Grove Road, #130, Rockville, MD 20850 Passi, 31. Date filed (Month, Day, Year) State Registrar's Signat DEC 06 2012 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Day 10 - Year 2012 Turnbu Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greenbelt 45 Ridge Road Prince George's . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 393-30-2020 Hours (Month, Day, Year) **Director** 1 M 2 DAE Iowa 1926 10a. State 10b. County within 72 hours efter death with the Maryland th end Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be positied at 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Greenbelt Maryland 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45 Ridge Road 20770 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ۵ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry S Co. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Schools Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harold G. Smyth Gladys Current 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health e Important. If item 27 is eny injury or other trai Alan J. Turnbull -husband 45 Ridge Road Greenbelt, Maryland 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/11/2012 Alexandria, Virginia 21. Signature of Funeral Service Licenses Don' I'd do Bolgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam The law requires that the death certificate be executed attending physiclan end for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 hes autons within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death

Natural

Accident

Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 2012 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) Drs Twee 003 Medical 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

DEC 2 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 6 2012 Elizabeth D. Varnev 3:26 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Ohio **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours 056-12-3238 91 May 16, 1921 Director 1 D M 2 X F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director must be notified Maryland Prince George's Greenbelt 1 X Yes 2 ☐ No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? 23a 110 Hedgewood Drive 20770 United States 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 27 is marked other than "natural", or iter traumatic event, the Medical Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. and 2 should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: White If Yes Give 3 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Prince George's Co. (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Schools Crossing Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I Leon Dingman Ruby Rice Macghee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Mary Dallavalle -daughter 2603 Readbourne Lane Davidsonville, MD 21035 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven Cem. 12/12/2012 |Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Dönald dod Borgwardt Funeral Home, PA <u>4400 Powder Mill Road Beltsville, Maryland 20705</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy performed?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔲 No ျပ 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🛛 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certify: These Prantitioner To the basis of my should get a the time data at place, and due to the cause(s) and manner accurred. 29a. Certifier To the I within 2 To the I only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 1)6426 12-06-2012 20 sm

DHMH 17 Rev 06-2011

State Registrar

KOYCE 31. Date filed (Month, Day, Year)

ARME

Box 68760

Division of Vital

2118

Registrar's Signature

Good Luck ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10b per FH G936 2/5/13 dk & 4c 2/20/13

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 3.55 PM BEEBE WILLIAMS DECEMBER 05 2012 /Medical Somerset 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner POCOMOKE CIT WOREESTER-POCOMOKE RIVER ROAD 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) Months Hours Min. 225 40 7624 1 ☐ M 2 🕱 F 79 JUNE 23 1933 VIRGINIA Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the Wedical Examinar roust be notified at Somerset 1 ☐ Yes 2 No Director POCOMOKE MARYLAND HUDREESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21851 7420 RIVER ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ 3 ₩ Widowed 4 Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) s 1 and 2 should be filed within if Health and Mental Hygiene. College (1-4or 5+) ESTATE AFENT REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MILTON BEEBE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WATSON CHINCOTEAGUG VIRGINIA 23336 MICHAEL SON 3818 MAIN STREET 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ament of H 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State DOWNINGS CEMETERY DEC 09 2012 ORK HALL VIRGIN 22. Name and Address of Facility For E HOLS TON FUNCE OF NOWE VIRGINIA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee CHINCOTENEUE 23336 5049 CHICKEN CITY ROAD n Dale tox VIRGINIA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on experience. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit and Due to (or as a consequence of) Box 68760. attending physician the death certificate be Physician/Medical as IF FEMALE: use If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy for Month Day Year 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number IOTE 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) State park Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician/ Month Year 2:39 Lewis Wood, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MICO If Under 24 Hrs. Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Months (Month, Day, Year) Director 212-26-2441 1 X M 2 □ F 6-8-1928 Maryland 84 L. Page 1 and 2 should be filed within 72 hours when the should be filed within 72 hours when the feath and Mental Hygiene.
Artant: If Item 27 is marked other than "natural", or items 23a or 28a-f show wrant: If Item 27 is marked other than "natural", or items 23a or 28a-f show orders. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Berlin Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21811 USA 62 Anchor Way Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Plywood Company 12 Warehouse Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ Wood Lillie Fox William Edgar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 Anchor Way Drive, Berlin, Maryland 21811 Elizabeth C. Wood - Wife Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State any Injury c 12-7-2012 rematory of Delmarva Delmar, Delaware 4 Donation 5 Other (Specify) 21. Signature of Furteral Service/Ligensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List oppone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBROVASCUCAR disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): NRUMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29d. Date signed (Month, Day, Year 101C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70 WAR O 31. Date filed (Mopt legistrar's Signatur Registrar

Bert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 5 Physician/ 10:45 P Harold J. Wood 20 TZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death
Caroline Caroline Nursing and Rehab Center Denton 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 927 292-24-0653 1 X M 2 □ F Months Days Hours Min. (Month, Day, Ohio Director 85 Usual Residence of Decedent or 28a-f show show 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Caroline Preston MD 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 must be n 21655 Funeral United States 21395 Tanyard Road items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian an "natural", or iter Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White, etc. δ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced WW II 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Plant Fabricator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked or ည Olive Scott Betsv Carl James Wood permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is markel any injury or other traumatic once. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21395 Tanyard Road, Preston, MD 21655 Frances Lee Steward/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State remetery, crematory or other place)

Fastern Sh. Veterans Cem unk 1 Burial 2X Cremation 3 Removal from State Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom Funeral Home, Christin Federalsburg, MD 21632 216 N. Main St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Jause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? cate has been signed by the atterpage 2 should be detached for Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cutic 2 No 3 ☐ Probably 4 ☐ Unknown ecurrent GI hiers 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 Yes 2 No 2 No Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificated filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

death (Item 23a) (Type, F

ORIGINAL

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registra

only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Decemb 2012 BARBARA JEAN WELLS Medical Facility Name (if not institution, give street and number) **Examiner** ation of Death 4c. County of Death 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In vrs. last birthday) Year If Under 24 Hrs. **Funeral** Months Min. Director 215-38-6826 1 □ M 2X F 71 OCT.29,1941 MARYLAND Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2XXNo MD CHARLES NEWBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 9850 SYLVAN TURN 20664 S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Force Black, White, etc. ō þ 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify I Hygiene. Specify: 3 Widowed 4 X Divorced Completed WHITE injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) RESTAURANT WAITRESS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of မ ANDREW AUGUSTUS WILLIAMS BERTIE BEATRICE OLIVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. ALLEN WELLS / SON 9850 SYLVAN TURN NEWBURG, MARYLAND 20664 altimore, 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST.MARY'S CH.CEMETERY 12/13/2012 CHARLOTTE HALL, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service Licensee Bal on 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Is (Lemic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner OYONONY Sequentially list conditions, Examine Due to (or as a cons au nce of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE Was decedent in the past 12 month yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent prednant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? has page 2 autopsy after death.

Director: After this certificate h 1 Yes funeral director, 25. Was case referred medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Tyes မှ 1 √ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred **V** Natural 5 Pending 1 Yes 2 No completely filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death curred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of c 29d. Date signed (Month) Dav. Year) 37 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) old 351 SONG MON MID

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's

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		_	1 - State Registrar			Cei	rtificate of	Death		Reg. No. ZUI	2	41118
	Physicia	an	1. Decedent's Name (First, Middle,	,					2. Date of De Month	Day Y	ear	3. Time of Death
	/Medic	al	Katherine E. 2 4a. Facility Name (If not institution,				4h City Town o	r Location of Death	Decemb	er 5, 201		6:24 p M
	Examin	er	1107 Walnut St		1201)		Delma			Wicon		
	Funeral				7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Bir (Month, Da	th y, Year)		ce (State or Foreign
	Director		220-03-1473 Usual Residence of Decedent	1 L M 2 L F	91	Yrs.			April 3	30, 1921		land
lone l	show ad at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation	· · · · · · · · · · · · · · · · · · ·			100	I. Inside City Limits
Mar	a-f st	Director	MD Wicor	nico	I	elmar			_			1 □ Yes 2 ☑ No
ă ţ	or 28 be no		10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country	y?
t dt c d	is 23a must	Funeral	1209 Walnut St	12. Was Dece	dent Ever in II	S 13 1	21875	lienanic Origin? (S		U.S.A.	America	Indian.
ָּבֶּ בַּי	r item		11. Marital Status1 ☐ Never Married 2 ☐ Marrie	Armed For 1 ☐ Yes	ces? 2 🔀 No		Was Decedent of H		o Rican, etc.)	Black,	White, etc	
U. Z. I. Z. 10-0000 filed within 79 hours after death with the Maryland	Francisco	d by	3 Widowed 4 □ Divorced	If Yes, Giv Year or Da	e ites:		1 □Yes 2XINo	Specify:		Specify:	whit	e
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A rithin	iene. than	ошо	Elementary/Secondary (0-12)	College (1-	-4or 5+)	ine.	secreta	,		hosp	oital	
	other vent,	Be C	17. Father's Name (First, Middle, L.	ast)					ne (First, Middle,	Maiden Surname)		
y	Menta arked atic e	70 E	Daniel Seth Mo	cQuay				Helen	Graff			
2	A fleath and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationshi							er, City or Town, St		Code)
, o	Health Health em 27 other t		Patricia Mense	er (Daug			Walnut		Delmar,	MD 2187 20c. Location - Ci		n, State
5	ayes ent of nt: If it		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		state		esition (Name of matory or other place of Faith	i	0-2012	Baltimo	۰ م. ۱۷	laryland
	peniar rayso a tank a notation and municipe peniar rayso a tank a notation of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Maones.		21. Signature of Funeral Service Li		Gai	22	2. Name and Addre	ess of Facility		Dareimoi	, 1.	aryzana
2 8	88 5 8 8			ct-Jen		1	Short Fun 3 E. Gro	ve Street	: Delmar		940	
			23a. Part 1. Enter the disease, or c shock, or he rt failure. List o	omplications that ca nly one cause on ea	aused the deat ach line.	th. Do not ent	er the mode of dyi	ng, such as cardia	or respiratory a	rrest,		Approximate nterval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	_	rinor	y arter	y dise	erse		_	
	xaminer			Due to (c	or as a consec	quence of):						
7		ner	Sequentially list conditions, cause. Enter Underlying	b. Due to (c	or as a conse	uence of):						
ecuted	and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
be ex	ysician and	cal Ex	resulting in death) Last	Due to (d	or as a consec	quence of):						
The law requires that the death certificate be executed	attending physi			d								
y cert	endinç use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregn		☐ Ectopic pregnanc	24		23d. Date	of deliver	У
deat C	he attred for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of		Other (specify)			Mont	h [ay Year
the the	d by the	Phy	9 Unknown Part II. Other significant condition			culting in the u	ndarlying cause giv	en in Part I	23e Did t	obacco use contrib	ute to the	cause of death?
ires #	s been signed to	d by	rait ii. Other significant condition	is contributing to de	alli put not res	suiting in the d	ndenying cause giv	eriii Faiti.	1 🗆			bly 4 🗆 Unknown
	been	letec						_	24a. Was	an 24b We	ere autop:	sy findings available
he la	cate has	Completed							auto perfo	psy pri prmed2 de	or to com ath?	pletion of cause of ! □No
ian:	certificate li rector, page	ø	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes ath (Check only o		_ res 2	: LINO
hvslc	this certifica al director, p	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Ir	npatient 2] ER/Outpatie		4 LI Nursing F	lome 5 Resi	dence 6 ☐ Other	(Specify)	
or Attending Physician:	h. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending		of Injury h, Day, Year)	28b. Time o Injury	Wor	ryat 'k?]Yes 2 □ No	28d. Describe	how injury occurred	1	
Attend	death ctor: y the	ficat	2 Accident investiga 3 Suicide 6 Could no	ot be 28e, Place	of Injury - At h	ome, farm, str	reet, factory, office	ites 2 lino	28f. Location (Street and Number	or Rural	Route Number,
	after I Dire	Certification:	4 Homicide determin	buildin	ng, etc. (Speci	ry)	, ,,		City or To			
Hospital	within 24 hours after death. To the Funeral Director: completely filled in by the fu		(Check only 2 Medical E	Physician: To the examiner: On the ba	asis of examin							
To the I	ithin 2 o the lompler	Medical	one) 29b. Signature and title of certifier	and mann	er stated.		29c. Licens	se number		29d. Date signed	Month, D	ay, Year)
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,	2 C1		3 Name and Juss of person w	ho completed cause	e of death (Ite	m 23a) (Ty p e,	Print)	0		< ,	, .	2 UD 21801
١	0		Congine Jac	ERAH MU	-	05 He	mberon	- by a	uti 101	Jetis bu	y V	M) 91801
	Stat Registra		31. Date filed (Month) Pay, Year)	2012	gistrar's Sign	A. A	back					
				4 1		0 0	or addition of the same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 2:55P M John B. Zistl, Jr. 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cecil E1kton <u>401 Appleton Road</u> 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 🛛 M 2 🗆 F Months Hours (Month, Day, Year) 12/12/1944 Delaware 67 Director 222-26-7684 Usual Residence of Decedent show er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Tes 2 X No E1kton Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 21921 United States 401 Appleton Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black. White, etc. Completed by 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HVAC **HVAC Contractor** e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Annie Cornelia Denham John B. Zistl Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 402 Chestnut St. AptB, New Castle, DE 19720 Sandra J. Zist1/Wife timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ₹ permit. Page 1 Department of Important: If it any injury or o ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 12/14/2012 Elkton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gilpin Manor Memorial Park Signature of uneral Service Licens 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. (. 259 East Main St., Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Liver Physician/ Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the luneral director, page 2 should be detached for use as the bunial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 1 Yes 2 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: ျှ 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 🔀 Natural (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

10

only one)

31. Date filed (Month, Day

29b. Signature and title of certifier

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
2533 AUGUSTINE HERMAN HWY,

DO062140

1 SUITE A

SHAHNAWAZ KHANMD

29d. Date signed (Month, Day, Year,

CHESAPEAKE CITY, MD21915

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g935 1-8-13 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Elijah Joseph Kenzo Adams Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month cember Medical Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Hopkins 1 timore Johns Itospita N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Months 093-99-2848 Days Hours Country) Director 1**X** M 2 □ F 10/25/2011 MD or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits DC N/A Washington 1 ☐ Yes 2 X No 15. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2229 14th St. 20020 U.S.A. Funer 12. Was Decedent Ever in U.S Armed Forces? 11. Mantal Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) à Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A N/Apermit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chaunsey K. Adams Danielle A. Rayside 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle Rayside (Mother) 2229 14th St. N.E. Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation, 5 ☐ Other (Specify) On-Site Crematory: 12/19/12 Baltimore, MD 21. Signature of Funeral Service Livers 22. Mosephss H Facili Brown, Jr. Funeral Home PA 2140 N. Fulton Ave. Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Thermalinjury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 10 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔲 Natural 5 Pending injury Electrical fire at home November 16 2012 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 11:45 AM 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 431 N. Montford AVL Home Medical Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death only one) of at the time, date and place, and due to the causa(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kara Biur MD St. Baltimore, 1800 Orleans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland State of Maryland Registrar		artment of H <i>tificate of D</i>			liene leg. No. 20	12 41781				
Ĺ	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Thelma Nina Adams				2. Date of Dea	th	3. Time of Death				
-	Medic Examin	cal	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	Decembe	er 20,20					
7352	LAdilli		2109 Mark Street		Bel Air			Harford					
H	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 219–23–6278 1 \(\text{ M 2 \text{ X}} \) F 79	**	If Under 1 Year Months Days	If Under 24 Hrs, Hours Min.		Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)					
_			Usual Residence of Decedent	Yrs.			Feb. 23	1933	Maryland 10d. Inside City Limits				
	aryland a-fsh ified a	Director	10a. State 10b. County 10c. City, T Maryland Harford Bel		cation				1 Yes 2 X No				
	the M a or 28 be not		10e. Street and Number	ALF	10f. Zip Code			10g. Citizen of					
	th with ms 23; must I	Funeral	2109 Mark Street	140.1/	21015	i- O-i-i-2 (C-	acifu Van ar Na	USA	According to the state of				
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ★Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ ★No If Yes, Give Year or Dates.	lf	Vas Decedent of His f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		ce - American Indian, ck, White, etc. :: white				
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212	within rgiene. rer thai		Elementary/Secondary (0-12) College (1-4 or 5+)	Secret	,			Sand &	Gravel Company				
pue	e filed wit ntal Hygie ed other event, th	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam		Maiden Surnam	e)				
Maryland	should be file and Mental I 7 is marked o raumatic eve		Joseph Vesely 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ig Address (Street a			City or Town, S	State, Zip Code)				
	nd 2 sh ealth ar n 27 is er trau		Kimberly Neukum/daughter		Fairland								
Baltimore,	ge 1 and nt of Heal : If item :		1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State cem	e of Dispo etery, crem	sition (Name of natory or other place	9)	Date		- City or Town, State				
Itim	permit. Page 1. Department of I Important: If it any injury or of		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Stephanie Cust	o Cre	matory, I	nc 12/2	21/2012	Baltin	nore, Maryland				
B	permil Depar Impor any in		Megrani ("lles	29	99 Freder	ick Road	Baltimo	ociety re,Mary	or Maryland, Inc.				
	Physician Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each in the limited sease or condition resulting in death) Sequentially list conditions, if any, reading to in realist cause. Enter Underlying	mer ice of):	s dise		Interval Between Onset and Death						
09/	death certificate be executed ne attending physician and ed for use as the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	ice of):									
. Box 687	death certifi ne attending ed for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnance 1 ☐ Live Birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic pregnanc Other (specify)	y 			ate of delivery onth Day Year				
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Vita	ysiciar s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatien	Othe	r: 4 Nursing H	ome 5 Resid	ence 6 🗆 Oth	ner (Specify)				
of	ing Phys ifter this uneral di			Bb. Time of injury	28c. Injury work	at	28d. Describe he						
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre		Yes 2 □ No	28f. Location (S City or Tow		per or Rural Route Number,				
_	the Hospital in 24 hours : the Funeral I npletely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination at 3 Certifying Nyrse Practitioner: To the best of my	nd/or invest	tigation, in my opinio	n, death occurred a	t the time, date ar	nd place, and du	ue to the cause(s) and manner stated.				
	To t		29b. Signature and title of certifier		29c. License	Sheet		29d. Date signe	2//2012				
	Sta	te.	30. Name and address of person who completed cause of death (Item 23 / Constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constant of the constan	5	Main .	Sheet	Stop ,	Hampst	ead MD 21074				
	Registr		31. Date filed (Month, Day, Year) DEC 2 7 2012 Lever S. Signature DEC 2 7 2012										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 0 1 2:00pM Sterling Augustus Alban Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Manchester 3669 Basler Rd. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 6,1925 Hours Days Maryland Director 87 219-14-8234 1X□ M 2 □ F Usual Residence of Deceden item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Directo 1 ☐ Yes 2 🖾 No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3669 Basler Rd. 21102 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dairy Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F :. Page 1 and 2 should be fil tment of Health and Mental tant: If item 27 is marked ည Ethel Marie Martin Earl A. Alban 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 3669 Basler Rd. Manchester, MD. Ruth A. Alban - wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or once. ö New Lutheran Cem. Dec. 26,2012 Manchester, 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Stall 3 21102 3296 Charmil Dr. Manchester, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury) Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform eral Director: After this certificate if 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying/Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certific

TERESA HAMYOK

31. Date filed (Month, Day, Year)

DEC 2 7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

2973

32. Registrar's Signature

MANCHESTER

DODS1816

MANCHESTER

29d. Date signed (Month, Day, Year)

			AMEND #1, PER MI	Type or Pri	nt in 1 27/1 arylan	Black	<mark>Indeli</mark> partme	ble In lent of F	k. Ens Health	and N	All Copie Mental Hy	s Are	Legi	ble.		
			1 - State Registrar				ertifica						.20	12	41	783
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	1 and 2 s of Health item 27 other tra		Steven Jones/A	ttorney	1				Ct.,		tminste					
Dalilli III E,	4 O + L		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	C	Place of Dis emetery, cr	rematory or	other plac			Date	20c. L	ocation - C	City or To	wn, State	
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	Medical Medical Examiner	al Examiner	Immediate Cause (Final disease or condition resulting in death) Securitiely is a condition of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a)	consequ	,	elor	na (10	7 mi	ral)				9 1 non	
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5	Attending or death. octor: After by the fune	icat	1 Natural 5 Pending 2 Accident Investigation		Year)	injury	М	work	(? Yes 2 □	No						
	5 # 5 =	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined				street, facto	ory, office			28f. Location (City or Tov			or Rural	Route Numb	er,
	in 24 hours after he Funeral Dir pleted filled in	Medical	(Check 2 Medical Exam	ysician: To the best of onliner: On the basis of express Practioner: To the l	amination	and/or inv	estigation, i	n my opinio	on, death o	ccurred at	the time, date a	and place	, and due t	to the cau	use(s) and ma	nner stated
F	within 2 To the Completed		29b. Signature and title of certifier				29	9c. License	e number			29d. Da	te signed (Month, L	Day, Year)	
			Muho for	57				Daa	655	8:	2	12.	-12-	201	2	
			30. Name and address of person who	Obsu	, 5	34	, Print) N	1011	land	11	tonse	7	Co	Ne	ssyl	250 T
	Sta Registra		31. Date filed (Month, Day, Year) NFC 2 0 20	32. Registra	r's Signat	ture	and and	•								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Laura D. Akers 12 1:55 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pineview Future Care Clinton Prince Georges Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min. (Month, Day, Year) Director 250-42-2284 1 □ M 2 🕅 F Yrs. June 16, 1928 SC shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Fort Washington MDPrince Georges 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2729 Wood Hollow Place 20744 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 ☑ Widowed 4 ☐ Divorced **Black** Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ should be John Daniels Lila Reese other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Page 1 and 2 <u>Deborah A. Akers - Daughter</u> 2729 Wood Hollow Place Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1 Burial 2 Cremation 3 Removal from State injury or Metropolitan Crematory 12-21-2012 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each tree Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours efter death.

To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗶 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie O LINE CENTER WALTOUFING, 20602

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** JR. 11:07 PM AMOERSOM ິເລ MARSHALL 2012 DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A HOSPITAL MEDSTAR HARBOR If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) XOM 2□ F Months Days Hours 48 09-29-1964 Maryland 214-86-8022 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Tx Yes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21226 U.S.A. 3909 Fairhaven Avenue Apt. B 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10College (1-4or 5+) N/A Crain Operator Curtis Bay Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marshall Anderson Sr. Bettye Gean Freeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danny Anderson Sr. (brother) 3909 Fairhaven Avenue Apt. 3 Baltimore, Md 21226 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 12-17-2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee Ashley Kelley MO1682 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final WITH INFECTIVE 6HOOCARDITIS SEPTIC S tho CK disease or condition resulting in death) Due to (or as a consequence of): MRGA BACTEREMUA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ∏Yes 2 ∏No 9 Unknown

Physician /Medical Examiner

Department of Health ar Important: If Item 27 is any Injury or other trau once.

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experience must be exalified at

Pages 1 and 2 should be filed within 72 hours after death with the Innert of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Examiner attending physician and for use as the burial-trans signed by the a Certification: To Be

Physician/Medical Completed by

The law requires that the death certificate be executed After this certificate has been s funeral director, page 2 should spital or Attending Physician: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, pa To the Hospital o within 24 hours aff To the Funeral Di completely filled in

Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	g cause given in Part I.		se contribute to the cause of death? No 3 Probably 4 Munknown
				24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 🖸	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	S ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could not be determined			ory, office	28f. Location (Street and City or Town, State,	d Number or Rural Route Number,)
	nysician: To the best of my kn niner: On the basis of examin and manner stated.				and manner as stated. I place, and due to the cause(s)

RES OOL

STREET

BALTIMORE

(Check only one) 29b. Signature and title of certifier

7

29c. License number

29d. Date signed (Month, Day, Year)

2012

DECEMBER 12,

21225

MARCION n(D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHICA HAMOUER RBEIRD

ST 3001

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2012

DHMH 17 Rev 1/2001

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #25, per me, g947 1-29-14 sm Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OUR N/A Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Country UNK Director 1 M 2 □ F Yrs. MD 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mydical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1821 Park Avenue 21217 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) Cook's Helper Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Roosevelt Byrd Grace Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Wilson (Sister) Eutaw Pl. Apt.528 Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ott Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) On-Site Crematory Baltimore, MD 21. Signatule of Funeral Service Licensee Name and Address of Facility rown Jr. Funeral Home PA MD 21217 40 N. Fulton Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of TINER OVED BY MEDICAL EX Physiclan/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed lipage 2 should be det 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No 24a. Was an autopsy performe this certificate Yes 2 No funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred 1XNatural iniury 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in muccinia 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWARDS 2000 WEST BALTIMORE STREET BALTIMORE ALLISON 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 21^{Day} Physician/ Dorothy Broadnick 2012 6:19 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Pasadena 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X Days Hours 1 1 7 1 3 / 1 9 2 0 92 Yrs 130-18-4662 N.Y. Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County the Maryland Director Pasadena Anne Arundel MD 1 🗆 Yes 2 🔀 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be U.S.A. 21122 Funeral 7922 Liberty Circle within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates. 14. Race - American Indian 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Black, White, etc. 9 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black han "natural", o Medical Exan 1 ☐ Yes 2X No Specify: Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with.
Mental Hygiene.

→ of other than "P.

→ the M (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N.Y. Board of Ed. Cook Manager 12th traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 Edgar Green Carrie Bell Mulligan . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7922 Liberty Cir. Pasadena, MD 21122 Patricia Mayfield (Dghtr.) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD On-Site Crematory 4 Donation 5 Other (Specify) 21. Sign full of Full eral Service Libe 22. Josephires Hi Faciliy rown, Jr. Funeral Home PA Baltimore, MD 21217 2140 N. Fulton Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Infumoni Medical ue to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician a detached for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant
9 Unknown Pregnant at time of death 2 No 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? atrial fibrilitation 24a. Was an certificate has autopsy performed? 2 🗌 No 1 ☐ Yes 2 📈 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: al or Attending P s after death. I Director: After t d in by the funers 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) 58510 21

Registrar

31. Date filed (Month, Day,

ar) 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lula Marselle Barbary 11:07P. M December 23,2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Towson Gilchrist Hospice Center i. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral York, S.C. Days (Month, Day, Year, Hours Months 251-38-9132 82 Director 1 🗆 M 2 🔀 F June 16,1930 Usual Residence of Deceder or than "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b County 10c City Town or Location 10a State Director 1 Yes 2 XNo Baltimore County Parkville Maryland 10g. Citizen of What Country? United States 10e Street and Number 10f. Zip Code 21234 Unit 3409 Funeral 8800 Walther Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ≥ 1 Never Married 2 Married Maryland 21215-0036 72 hours aftar 1 ☐ Yes 2X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Public Schools School Teacher 12 06 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba filed end Mental F is marked of Leila Jeanette Neelands ပ္ John Franklin Kiser permit. Pege 1 and 2 should ba Departmant of Health end Ment Importent: If Item 27 is marke eny injury or other treumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6451 Cloister Gate Drive Baltimore, Maryland 21212 Mrs.Marla B. Carney / Daughter 3aftimore. 20c. Location - City or Town, State Harford County Forest Hill, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Pege 1 g cemetery, crematory or other place)
Evans Funeral Chapel and
Chemation Services Inc Wednesday 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Dec. 26, 2012 Signature of Funeral Service Licensee Teffrey L. Cair, Sr. CFS 22. Name and Address of Facility.
Peaceful Alternatives Funeral and Cremation Center, P.A. Fart 1. Enterthe disease, of complications that caused shock, or heart failure. List only one cause on each line. Lic.#M00677 Timenium, Maryland 2325 York Road Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a cons ^JExaminer 920921 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of signed by tha ettending physicien end d ba deteched for usa es the burlal-trensit Exa Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physicien: The law requires that the death certificete be Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 ☐ Unknown Completed 1 Yes 2 No To the Hoepitel or Attending Physicien: The law require within 24 hours efter deeth.

To the Funerel Director: After this certificete has been si completaly filled in by the funerel director, page 2 should Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Ves 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? Other: 4 Nursing Home 5 Residence ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending М Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur and title of 29d. Date signed (Month, Day, Year) 29c. License number FBS1F000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #4105, Balthusse up Snatreen, 6701 M. Charles St. te filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 7 2012

DHMH 17 Rev 06-2011

Registrar

Back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:07 P December 23,2012 Physician/ Deborah Kay Blair Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days July 28, 1954 Hours Director 212-58-3904 58 Maryland 1 🗆 M 2 🖾 F al Residence of Dec th and Mental Hygiene. 27 is merked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 1320 Deanwood Road 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mayor Office Career Development Facilitar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is merked o ၉ Russell Land Mattie Mae Mobley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s of Health item 27 Thomas Blair-spouse 1320 Deanwood Road-Baltimore, Maryland 21234 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1
Depertment of I
Important: if it
eny injury or of Evans Funeral Chapel and Cramation Services Belair 1 Burial 2 No Cremation 3 Removal from State Dec. 27, 2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
8800 Harford Road-Parkville, Maryland 21234 ordrace LM Stud 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ etacta disease or condition resulting in death) Medical Due to or as a consequence of): ^{*}Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir the ettending physicien end hed for use as the buriel-transit Hospitei or Attending Physicien: The lew requires that the deeth certificate be executed that initiated events Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy 3 in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the e Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate hes been sig ; pege 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funerel Director: After this certificate hes t completely filled in by the funeral director, page 2 s autopsy performed Yes 2 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Dice. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3[ly one) 29c. License number 29d. Date signed (Month, Day, Year) 821400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DADA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford 23 Patrick Court Abingdon 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Director 213**-**68-4212 1 □ M 2 🗓 F 55 July 3,1957 Guam or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland traumetic event, the Medical Examiner must be notified at Completed by Funeral Director Harford Abingdon 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a United States 23 21009 Patrick Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. Armed Force 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry grade completed) Harford Community end 2 should be filed within 72 Heelth and Mental Hygiene. tem 27 is marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Events/Planning Coordinator College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Billings Virginia Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth sitem 27 i 1541 Boggs Road, Forest Hill, Maryland 21050 Cynthia Smith / Sister 20a. Method of Disposition
1 ☐ Burial 2 Å Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F important: If ite any Injury or ot once. Page 1 Metro Crematory Inc. 12/19/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Tuneral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) 24 hours after death.

24 hours after death.

25 Funeral Director: After this certificate has been signed by the attending with several sections as the funeral director, page 2 should be deteched for use as the burial-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physicien: The law requires that the deeth certificate be to hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery Ectopic pregnancy Month 5 Other (specify) Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 D No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funel completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe

State

Registrar

31. Date filed (Month, Day, Year)

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month December Physician/ David Pau1 Bass, Jr. 9:00P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3503 Westview Road Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Country) Days Hours Min Director 213-28-8286 1 1 X 2 1 F June 6, 1932 80 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 📝 No M D Carroll Westminster 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3503 Westview Road 21157 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1950-53 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 1√2 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 Maintenance Mechanic Mechanical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Paul Bass Margaret K. Labor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Bob-El Drive, Westminster, MD 21157 Hope Bass (Daughter) permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Lake View Mem. Park 12/29/2012 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Signature of Funeral Service Licensee MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ 12 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 5 Other (specify) Pregnant at time of death been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy 1 ☐ Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: **≥** No ျှ 1 🗌 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 M Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [3 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) center St Westminster, Md Johanna Di Mento H.D. 555 S 31. Date filed (Month Day, Year) State Registrar

			AMEND #25	Please, PER ME	Type or G934 12	Print in	1 Black 2 TRT	Indeli	ble Inl	k. Ens	ure A	II Copie	s Are	Legi	ble.		
			For State Registrar		State of	iviaryia		eparime Sertifica			and iv		giene Reg. No.	2 በ	12	LI	792
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Maryland	d be file Mental H arked ot atic ever	To B	17. Father's Name (i Frank V	, , , , , , , , , , , , , , , , , , , ,								(First, Middle, Baldw:		Surname)			
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Donita	me/Relationship (Ellis	_{Type, Print)} (daught	er)	1 ^{9b. M}	ailing Addre 2 Ra	ess (Street a 1wor	and Numbe th Ro	er or Rural d . B	Route Numbe alto,I	r, City or Md 2	121	ate, Zip C 8	ode)	
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	Attending Physician: The law requires that the death certificate be executed by death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r	nonths?	23c. If yes, outcome of pregnancy									23d. Date of delivery Month Day Year			Year
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古Re	ician: The la certificate ha rector, page 3		25. Was case referre	ed to medical	<u> </u>				00. DI	ace of Deat	th (Ohnali	1 🗆 Yes	rmed? 2 No		eath?	2 🗆 No	
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Division	or Attending after death. Director: After I in by the fune	Certificate:	3 Suicide 4 Homicide	Investigation 6 Could not determined	28e. Place o	f Injury - At g, etc. <i>(Spec</i>	home, farm,			165 2 🗆	-	8f. Location (\$ City or Tow		Number	or Rural	Route Nu	mber,
	To the Hospital or Attene within 24 hours after death To the Funeral Director: of completely filled in by the	Medical (29a. Certifier 1 (Check 2	Certifying Phy	vsician: To the besininer: On the basis	st of my kno	owledge, dea	th occurred	at the time	e, date and	place, and	d due to the ca	ause(s) an	d manne	r as state	d. se(s) and i	manner stated
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			30. Name and addre	ess of person who			em 23a) (Typi		-\cas	e Q1	Jen 1	Balt	linear	· ela			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ pecember 18, 2012 7:00 Ам William Ernest Beall Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick College View Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Country) UNK Funeral 6. Sex 7. Age (In vrs. last birthday) April 4, 1936 Days 1 X M 2 A F Yrs. Director 217-32-6066 76 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🖾 No Frederick MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21702 800 Motter Ave; Apt 303 12. Was Decedent Ever in U.S.UNK Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: white "natural", 3 Uidowed 4 Divorced Year or Dates or other traumatic event, the Medical 16b. Kind of Business Industry un15. Decedent's Education 16a, Decedent's Usual Occupation 11n (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
700 Toll House Ave; Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) College View Nursing Home 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state Signature of Funeral Society Licentage of Signature of Funeral Society (Control of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of Signature of 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final disease or condition Perset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last been signed by the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed ours after death.

eral Director. After this certificate If filled in by the funeral director, page 25. Was case referred to medical Be 26. Place of Death (Check only one) 2**X** No Other: 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Natural 5 Pending 1 Tes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral Completed filled Medical 1) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Checl 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Y

196 TJONEVE, PECOPALCE, MD 21702

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12/18/2012 Ralph F. Baker 10:37 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 219-10-2851 Director 1 X M 2 □ F 86 6/28/1926 MD or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏹 No Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 104 S. Hilltop Rd. 21228 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any Injury or other traumatic event, the N District Manager Keystone Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Foster Baker Clara M. Hodges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Baker / wife 104 S. Hilltop Rd., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 12/22/2012 Elkridge, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 21. Signature Funeral Service Licenses Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ RESPIRATORY disease or condition Medical resulting in death) Examiner ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and ched for use as the burlal-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month after death. **Director:** After this certificate has been signed by the a d in by the funeral director, page 2 should be detached i g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 29 Other (Specify) ျ 1 🗌 Yes 2 X No HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation 3 🔲 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar DHMH 17 Rev 06-2011

Q.

CEDAR

6336

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sam Brocato Anthony 8:00 PM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1612 B Rebecca Ct. Harford Forest Hill Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 219-16-3554 Director 1 X M 2 D F 88 Feb. 5,1924 Marvland Usual Residence of Decedent 28a-f sho 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Forest Hill 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1612 B Rebecca Ct. U.S.A. 21050 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give WW II
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3★Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs Architect Architectural Firm of Health end Mental Hygle If item 27 is marked other or other treumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Salvatore Brocato Maria Portera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1612 B Rebecca Ct. Forest Hill, MD 21050 Mr. Larry Brocato - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Depertment of H
Important: If ite
eny injury or ot Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Dec.28,2012 Baltimore, MD Signature of Funeral Service Lic 22. Name and Address of Facility Baltimore, Maryland au 5305 HArford Rd. Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OBSTRUCTI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami ettending physician and for use es the burial-transit Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the etter completely filled in by the funerel director, page 2 should be detached for a in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Division Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 📃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY

VALLEY

MD

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Ethel May Buckingham Physician/ 2012 December Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 6218 N. Walnut Ave. Carroll Sykesville If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Min 220-12-6171 **Director** 1 □ M 2 🛣 F 88 May 1, 1924 Usual Residence of Decedent 10c. City, Town or Location 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho MD Carroll Sykesville 10g. Citizen of What Country? ō 10f. Zip Code 10e. Street and Number Funeral 21784 United States 6218 N. Walnut Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married 1 Yes 2 No þ 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 K Widowed 4 □ Divorced Completed Year or Dates other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Btock Room Marker G.C Murphy and Company 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Page 1 and 2 should be Sterling Ezra Blacksten Lula May Yingling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy L. Smith (Daughter) 6218 N. Walnut Ave. Sykesville, MD 21784 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 12/28/2012 New Windsor, MD 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 22. Name and Address of Facility Signature of Funeral Service Licensee Surrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 2178 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) masca Medical Due to (or as a consequence of) **Examiner** Seque: tially list condition Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Division of Vital Records, Completed 24a. Was an autopsy performe s certificate has b director, page 2 s Yes 2 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: ၉ 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at Certificate: 5 Pending Natural in 24 hours are. ____he Funeral Director: Aft 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2, To the F complet only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month, Day, Yea) (2 enter St. Westminster no

6:40 P M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Interval Between Onset and Death

Year

Unknown

1 🗌 Yes 2 🙀 No

MD

State Registrar OHMH 17 Rev 06-2011 29b. Signature and title of certifier

31, Date filed (Month, Day Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012ª E. Dec. 7:05 P^{M} Asta Brende1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10924 Harmel Drive Howard Columbia Social Security Number If Under 1 Year If Under Funeral . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Months Davs Hours (Month, Day, Year) Director 124-24-6267 1 🗆 M 2 🔀 F 89 Yrs 03/28/1923 Usual Residence of Dece Germany or 28a-f show notified at 10b County 10c. City, Town or Location the Maryland **Funeral Director** 10d. Inside City Limits MD Howard Columbia 1 Yes 2X No 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? pe 23a with 10924 Harmel Drive 21044 must ! United States items and 2 should be filed within 72 hours after death Health and Mental Hygiene. tem 27 is marked other than "natural", or items other traumatic event, the Medical Examiner muster traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: 3X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٩ Franz B. Krone Erna Luedke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Roderick - daughter 10924 Harmel Drive Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Cntr of MD 12/26/2012 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician STAGE Gnyy EMA disease or condition Medical resulting in death) Due to (or as a c sequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical certificate be Box 68760 as the IE EEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months?

1 Yes 2 XNo Month Pregnant at time of death Other (specify) Day Year 1 Yes 2 9 Unknown detached g Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has performed? Yes 2 A No 2 🗌 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 A Residence 6 \square Other (Specify) 2 XNo 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at **X**Natural 5 Pending 1 Tes 2 🗌 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat 29d. Date signed (Month, Day, Year) Dec. 26, 2012 4868

State Registrar

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Column is

21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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CMBA

12-09715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Earline Boulware	State of Maryland / Department of Healt 1-For State Certificate of Death Registrar	Reg. No. 2012 11798										
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Pear December 21, 2012 3. Time of Death 0038 hrs										
		own, or Location of Death 4c. County of Death NA										
Funeral Director	218-56-0199 1_M 2\XF 60 Yrs. Months	r 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) MD										
w any	Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 X Yes 2 No										
the Maryland to 128a-f shnw diffed at once. Director	MD NA Baltimore 10e. Street and Number 10f. Zip 2822 Harlem Avenue											
er death with the Maryland , or items 23a nr 28a-f shu r. must be notified at once. Funeral Director	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent If Yes, specify	nt of Hispanic Origin? (Specify Yes or No- y Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African										
2 hours aft "natural" il Examine eted by	or Dates:	No specify: Specify: American Occupation (Give kind of work done king life. DO NOT use retired) ional Officer State of Maryland										
21215-0036 Juld be filed within 7 Mental Hygiene marked other than cerent, the Media		18.Mother's Name (First, Middle, Maiden Surname) Lena Wise										
MD 2121 ad 2 should be fit alth and Mental Im a 27 is marked m 27 is marked To Be	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Rural Route Number, City or Town, State, Zip Code) herne Road Baltimore, Maryland 21229										
Baltimore, MI permit. Pages I and 2 s Department of Health a Impurtant: If iten 27 injury or other traum.	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Nar crematory or other place) Metro Crematory	ory 12-27-12 Catonsville, MD										
Balti permit. Departu Impurt injury	638 N.	Address of Facility Wylie Funeral Home P.A. Gilmor Street Baltimore, Maryland 21217										
Physician Medical Examiner	23e Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death										
9	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):											
0, be executed sician and purial - transit edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.											
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Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law equires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate last leen signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Ledical Certification: To Be Completed by Physician/Meledical Certification: To Be Completed by Physician/Meledical Certification:		3 Ectopic pregnancy Month Day Year										
P.O. B es that the d gigned by the of detached by the bed that he detached by the by Phy	Cocaine Use	cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown										
Division of Vital Records, P.O. ral or strending Physician: The law requires that it is after death. al Director: After this certificate as leen signed by led in by the funeral director, page 2 should be detach perfication: To Be Completed by F		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No										
ital Recision: The sician: The irector, page	25. Was case referred to medical examiner?	26.Place of Death (Check only one) OA Other Nursing Home 5 Residence 6 Other:										
Division of Vital Req To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page ledical Certification: To Be Con	1 V Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 28 Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	26c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No										
Division or spital or Attending tours after death. neral Director: After filled in by the funer filled in by the funer Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory	, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
To the Hospital within 24 hours To the Funeral completely filled		y opinion, death occurred at the time, date and place, and due to the cause(s)										
P F S F S	29b. Signature and title of certifier 29c Aug. Aug. M. H. A. J. R. L.	O.C.M.E. OGME 29d. Date signed (Month, Day, Year) December 21, 2012										
Ingal.	30. Name and address of person who completed cause Peath (Item 3a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore, MD 21223										
State Registra	e 31 Date filed (Month, Day, Year)											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William Jean Pierre Byrne 2012 9:50 a^{M} December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Althea Woodland Nursing Home Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 568-46-2817 1 🗙 M 2 □ F 84 March 02.1928 France Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Silver Spring Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20902 11505 Soward Drive u.s.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces? 1X Yes 2 □ No 1950-Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify: Caucasian If Yes, Give 3 Widowed 4 Divorced 1952 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Technical Information Manager |Information Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeanne Irene Randonnier William Elmer Burne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11505 Soward Dr., Silver Spring, Maryland 20902 Jane Dillencourt Byrne - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 01/03/2013 Brentwood, Maryland Signature of Juneral Service Licensee 22. Name and Address of Facility
Simple Tribute Funeral & Cremation Center
1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZITEIMER'S DISEASE disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence bi). Due to (or as a consequence of): 23d. Date of delivery Month Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 2 No 26. Place of Death (Check only one) Hospital: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner that the death certificate be executed physician and the burial-to Box 68760 attending ? nse Po P.O. Records, has Hospital or Attending Physician: Division of Vital s after dea. ral Director: Afte filled in by 24 hours To the Hosp within 24 hor To the Fune completely fi

Physician/

Medical

Examiner

Funeral Director

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Examiner

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permit. Page 1 a
Department of h
Important: If ite
any injury or ot

Physician/

Medical

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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Examine Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown þ USHOPONSIS Completed HypoThyroidISM 25. Was case referred to medical examiner?

1 Yes 2 No Be မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 🔼 Natural 5 \square Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

D01852

work? 1 \(\text{Yes} \) 2 \(\text{No} \)

28c. Injury at

28f. Location (Street and Number or Rural Route Number, Cify or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28b. Time of

DE VORE MD 4203 CLUEENS DURY Rd Hynthille Med 20181

31. Date filed (Month, Day, 32. Registrar's signatur

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 12:42 PM **Physician** Eugene December 25 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min. 1X M 2 □ F 213-36-2103 71 April 6,1941 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County rral", or items 23a or 28a-f show Examiner must be notified at 10a. State 1 ☐ Yes 2X No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1333 Willow Road 21222 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 3NO Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: ģ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) School Bus Driver Baltimore County 11 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Eugene Baker Anna Mary Illian ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John A. Baker Son 2401 Ruth Ave. Edgemere, Maryland 21219 of Health Pages 1 ; ment of H 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December permit. Pages
Department of
Important: If it
any injury or o
once. 1 XBurial 2 Cremation 3 Removal from State Aberdeen, Maryland Harford Memorial Gardens 31, 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Parl 1. Enter the disease, of complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a, Part 1. Enter the disease. Onset and Death Immediate Cause (Final Pheumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** una ancer Sequentially list conditions, if any, leading to immediate Examine Due to (or 34 a consequence of) cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 physiciar Physician/Medical use as f IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Vear Pregnant at time of death 5 Other (specify) 2 No be detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 2 No 3 Probably 4 Munknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes 2 No 1 Depatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? after death. Director; After t Certification: Natural 2 Accident 5 Pending investigation (Month, Day 1 Yes 2 🗌 No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of or RESIDO December 25, 2012 MIT

DHMH 17 Rev 1/2001

State Registrar 4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

houstopher

Year)

31. Date filed (Month, Day),

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 = For State Registrar	State of Marylan	d / Department of Health and I Certificate of Death	Mental Hygier	2012	41801
	Physici	an	Decedent's Name (First, Middle, Last T	Bonner	W 4 4	2. Date of Death	4 2012	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4e-County of Death	
			Futuve Ca 5. Social Security Number 6. Se	re Cold Sp x 7. Age (in yrs.	VING BULT MOSE last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Dalti 9. Birth	place (State or Foreign
	Funeral Director		244 -48-6968 10	□M 2 V F √ 6	Yrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yea	126 N.	CAROLINA
	show	_	Usual Residence of Decedent 10a. State 10b. County	10c. gr	y, Town or Location		•	10d. Inside City Limits 1
	y wihin 72 hours after death with the Maryland jiene. r then "naturel", or Items 23e or 28e-f show the Medical Evanturer must be notified at	Director	10e. Street and Number		ATIMORE 101. Zip Code	10g.	Citizen of What Cou	
	s 23e o		1911 N. ALSQ	with Stre	ET 21218	V	1. S. A	F
9	after de or Items	Funeral	11. Marital Status 1 Never Married 2 Marned	12. Was Decedent Ever in U. Armed Forces 1 1 ☐ Yes 2 ☑ No ff Yes, Give	.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Q	
-003	thours sturel',	ed by	3 Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a. Decedent's Usual Occupation		Kind of Business/li	ndustry
21215-0036	within 72 ene. then "nai	Completed	(Specify only highest grad		(Give kind of work done during most of wor life. DO NOT use retired)	king	6. 00 1/0	Hanso
	Hys the	Be Co	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	en Sumame)	TIVALES
Maryland	should be and Mental marked c	ToE	ROBERT WI	MAMS, B	R. LOSS 19b. Mailing Address (Street and Number or Ru	SIE PU	RVIS y or Town, State, Zi	in Code)
	nd 2 salth ar 27 is r treu		19a. Informant's Name/Relationship (T	ATSON	1911 A. A. Saul A	5+ BA	Hto Me	1.21218
ore	0 0 -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	Plade of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or T	Town, State
Baltimore,	permit. Pag Department Important: I eny injury o	- 4	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	/ ///	22 Name and Abdress of Facility	JONES	Ja. Ei	in Sucha
8	89758	(A) 1)	Sleve (d	amo me	b. Do not enter the mode of duing such as cardia	ic AUBA	4 to m	Approximate
R	Physician	v v	shock, or heart failure. List only of Immediate Cause (Final disease or condition	A In	h. Do not enter the mod of dying, such as cardiac e Heart Failure	or respiratory arrest,		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	aDue to # r as a conseq				
	P =	ner	if any, leading to immediate cause. Enter Underlying	b Due to (or as a consequ	uence of):			
	ate be executed hysician and the burial-transit	Examine	Cause (Disease or injury	c	uence of):			
8760	cate be physicial the buri	icai		d				
Box 6	eath certific attending p I for use as I	in/Me	230. Was decedent pregnant	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta			23d. Date of deli-	
O. B	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transil	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 Pregnant at time of de			Month	Day Year
a	res that t igned by be detar	by Ph	_		rulting in the underlying cause given in Part I.			the cause of death?
cord	w require been sign	ompieted	pneumonia,	Senile der	MENLTIC	1 ☐ Yes 24a. Was an		topsy findings available
Vital Records,	The ate h page	Comp				autopsy performed	? prior to c death?	ompletion of cause of 2 No
Vita	dertific rector,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 € No	Hospital:	Other	th (Check only one)	C DOther (Case	7. A.
n of	ftel ne	-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 □ DOA 4 Nursing H 28b. Time of	ome 5 Residence 28d. Describe how in		iny)
Division	Atten dea ctor y the	Certification;	2 Accident investigation 3 Suicide 6 Could not be	286. Place of injury - At no	M 1 ☐ Yes 2 ☐ No ome, farm, street, factory, office	28f. Location (Street		ral Route Number,
ă	urs after rel Dire		4 Holnicide	building, etc. (Specify		City or Town, St		
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in E	edicai			owledge, death occurred at the time, date and place ation and/or investigation, in my opinion, death occu			
	To the within To the comp	W	29b. Signature and title of certifier	n crip	29c. License number K12093 8	29d.	Date signed (Month	Day, Year)
	かく		30. Name and address of person who c	ompleted cause of death (Item	es Rd Parkville	mp a	11234	
	Sta Registr		31. Date filed (Month Day, Year)	32. Proistrar's Signa				
			UEL & I &	112 January	A Maria			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 Month 19 Day 2012 Year 8:51 AM Brumfield A. Barnes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hosp. 8. Date of Birth
(Month, Day, Year)
May 21,1961 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Country) MD **Director** X M 2 D F 51 28a-f shov 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director Baltimore MD 1 🖵 Yes 2 🗌 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 21206 USA 23a Funeral 5214 Hillburn Ave. or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Marital Status 14. Race - American Indian, Black, White, etc þ 1 Yes 2 No If Yes, Give Year or Dates. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmans. Elementary/Secondary (0-12) College (1-4 or 5+) Self employed <u>Mechanic</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Wiley H. Barnes Rosa Blow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franchester James (sister) 5214 Hillburn Ave. Balto, Md. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Cem. Dec.27,2012 Balto, Md. calvin B. Scruggs Funeral Home 21, Signatur 2 E Preston St. Balto, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION NEUMONIA O hrs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Unknown signed by the all Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed plnods Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? certificate Yes 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

State

s after death.

124 hours after e Funeral Directors of tilled in b

within 2 To the I

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completely

Medical

□ Accident

Suicide

3 🗍

KAKKAD

29b. Signature and title of certifier

31. Date filed (Mornin, Day,

4 Homicide

29a. Certifier

Investigation

determined

Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NION

MEDSTAR

Registrar DHMH 17 Rev 06-2011 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

EMORIAL

1 🗌 Yes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

2 No

HOSPITAL 201 EAST UNIVERSITY PARKWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2012

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Physiciar /Medica Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Phys /Me Exan

Funera Directo

		Type or Prings Fer FH State of Ma	nt in B ryland	lack ln / 08/ 2 / Depa	delible ink ortment of F	. Ens	ure A and M	II Copies	s Are	Leg	ible.		
	1 - State Registrar		,		tificate of L			,	Reg. No		112		20
	1. Decedent's Name (First, Middle, Las	st)			· · · · · · ·			2. Date of De	eath Da	<u> </u>	} 	3. Time of	Death
1	Frank Bin	Knwski						Decemb		21	2012	08:48	ДМ
r	4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	Location of	of Death		4c.	. County	of Death		
	Johns Hopkins Bayvie			. f. i.dl. ata. A	Baltimore	lf Lindor	O4 Uro	O Data of Di	-th-		O Dieth	-lane (Ctata as	Formion
	5. Social Security 14978 6. S 219–16–2 081 1. Usual Residence of Decedent	ex 7. Age	88 (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da 08/26	/192	24	Cour	place (State or itry) Land	roreigi
	10a. State 10b. County		10c. City,	Town or Loc	cation							10d. Inside Cit	y Limits
5	Maryland Baltimo	re	Dune	dalk								1 Tes	2 NO
ě	10e. Street and Number		-		10f. Zip-Code				10g. Cit	tizen of \	What Cour	ntry?	
ō	1708 Dundalk Ave	nue Apt. B	2		21222				Uni	.ted	Stat	es	
Funeral Director	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Ori ın, Mexicar	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.))-		ce - Americk, White,	can Indian, etc.	
Š	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	fy Yes 2 ☐ N If Yes, Give Year or Dates:	WWII		☐ Yes 2XX No	Specify:				Specii	* ****	ite	
ete	15. Decedent's Ed (Specify only highest gra			(Give I	lent's Usual Occup kind of work done DO NOT use retired	during mos	t of work	ing	16b. K	(ind of E	Business/Ir	ndustry	
Completed	Elementary/Secondary (0-12)	College (1-4 or 5			Metal Wo	,			Co	nsti	ructi	on	
	17. Father's Name (First, Middle, Last)			511000	110001		er's Nam	e (First, Middle	_				
0 De	Phillip Binkowsk	i				Agne	es Ma	aika					
=	19a. Informant's Name/Relationship (19b. Mailin	g Address (Street				ber, City	or Town	, State, Zij	p Code)	
	Jane Rogowski - N	iece		3310 I	Oublin Ma	nor E	Road	Street	, Ma	ryla	and 2	1154	
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)		20b. Pla Sac	red He	sition (Name of natory or other place PART OI	jesus		Date			•	own, State	
	21. Signature of Funeral Service Licen			22 Da	etery Name and Addre avid J. V 01 S. Che	<i>l</i> eber	Fune	eral Ho	mes	P.A	•	Maryla	
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Socral Due to (or as a	Vec a conseque	Ubita	us ulcev								
Pnysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal d	death 3] Ectopic pregnand] Other (specify) _	y					ate of delive		Year
5	Part II. Other significant conditions of	contributing to death b	ut not resul	ting in the u	ınderlying cause g	iven in Part	1.					the cause of c	
Del	Chastrointestinal	bleed									3 🗌 Pro		Jnknowr
npie	Atrial fibrillat	100						24a. Was		24b	. Were aut prior to c death?	opsy findings completion of c	available ause of
Completed	Recurrent urino	iry tract	int	ecti	ons			1 🗆 Yes	2 N	0	1 Tes	2 No	
ä	25. Was case referred to medical examiner?	Hospital:			• 3 DOA Oth	0.51		(Check only		_			
2	1 Yes 2 No 27. Manner of Death	28a. Date of Injur		R/Outpatien 28b. Time of	I 3 DOA	4 🗆 140		me 5 Res 28d. Describe			her (Speci	ify)	
callon:	27. Waitrel of Death X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day	Year)	Injury	M 1 _	y at k? Yes 2□	No					(B) (M)	
Certification:	4 Homicide determined	building, etc	c. (Specify)		eet, factory, office			Cify or To	wn, State	9)		ral Route Num	Jel,
Medical	29a. Certifier 1 Certifying Ph (check only one) 2 Medical Exam	nysician: To the best of miner: On the basis of and manner sta	examination	edge, death on and/or in	n occurred at the ti vestigation, in my	me, date a opinion, de	nd place, ath occur	and due to the	e cause(e, date ar	s) and n nd place	nanner as e, and due	stated. to the cause(s	s)
Me	29b. Signature and title of certifier				29c. Licens					-		, Day, Year)	7
	30. Name and address of person who	M MD completed cause of c	leath (Item	23a) (Tvpe.	RES Print)	-00	0		Dece	Mb	er Z	1,201	<u></u>
e	31. Date filed (Month, Day, Year)	WZ AY 32. Registra	,	, , , , ,		49	940 E	astern A	venu	e, B	altimo	ore, MD,	2122
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Registrar

DHMH 17 Rev 06-2011

Registrar

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		1- For State	O	tate of Mary		ertificate		iliu ivici	пап пуу				
Physici	an/	Registrar 1. Decedent's Name	, ,	. ,			-		2.	Date of De	Reg. No.	10 -	8. Time of Death
Medical Exam	iner			rd Beth					1	Month Decembe	Day er 10, 2012	Year	1703 hrs
		4a. Facility Name (1659 Colon		on, give street and r	umber)		4b. City, Town, Frederick					nty of Deatl	h
Funeral		5. Social Security N		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y			B. Date of B	irth(MM/DD/Y		thplace (State or
Director		135-50-	7431	11X M 2 F		56 Y	Months Da	ays Hou	rs Min.	12/13	3/1955	Foreig Co	gn puntry) NJ
Aus		Usual Residence of 10a. State	f Decedent 10b. County		Ino Cit	y, Town or Loc							
_ & 45		MD	1	lerick		Freder							10d. Inside City Limits 1 Yes 2 X No
ryland	햟	10e. Street and Nu					10f. Zip Code				10a Citiana at	C \ A (- 4 \ C - 1	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once,	Il Director	1659 C		al Way			21	702		10g. Citizen of What Count			ntry?
ith wi	Funeral	11. Marital Status 1 Never Marrie	ed 2 V		cedent Ever in U		/as Decedent of F Yes, specify Cub	Hispanic Or	rigin? (Speci	fy Yes or N		ace - Amer	ican Indian, Black,
er dez	Ξ	3 Widowed		1 Yes	2 X No								ite
urs afi tural	yd E			or Dates:		1 16a. Decede	Yes 2 X N			done	Speci 16b. Kind of	rry:	
72 ho	etec	Elementary/Seco			1-4 or 5+)		nost of working li				TOD. KING O	Dusinessi	industry
or tha	Completed	12 Cle							Rest	aura	nt		
15-C		17. Father's Name					-				Maiden Surna	me)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Donald 19a. Informant's Na			10h Maili	n Add (0)		oria					
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	-	Aja Goo	de S	Son		102	ng Address (Str Edinb	urgh	Walk	ersv:	ille M	ID 21	793
or He		20a. Method of Disp 1 Burial 2		sition (Name of o ther place)	cemetery,	D	ate	20c. Location	on - City or	Town, State			
Page ment tant:		4 Donation 5	Other S	pecify:	At		c Crem		12/1	-			nie MD
Baltimore, permit. Pages I ar Department of Hes important: If ite		21. Signature of Fu	neral Service	Licensee		22.	Name and Addre	ss of Facili	ity Sim	plic	ity Cr	em &	Fun Serv
Physician	-	23a, Part I, Enter th	e disease, or	complications that	aused the death	Do not enter	homasA.	llen	PA 70	90 R	idge R	td Ha	nover MD
/Medical		failure. List onl	y one cause	on each line.				g, such as	Caldiac of Te	spiratory en	rest, shock, or	пеап	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Methadone Intoxication Due to (or as a consequence of):											
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T :	хап	(Disease or injury the events resulting in o	a consequence o	of):									
ecuted and transit		rea .		d	00	03 0	0 5		005 1				
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Box 68760, e death certificate be exe the attending physician a		IF FEMALE: 23b. Was decedent j		23c. If yes,	outcome of preg		etal death 3	Ectoni	ic pregnancy			of delivery	
Box 68 e death certifi	icia	past 12 months		4 Preg	nant at time of de	noth -	ther (Specify)	Lctopi	ic pregnancy		Month	, _	Day Year
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Division of Vital Records, tal or Attending Physician: The law requirers after death. 14 Director: After this certificate has been sited in by the funeral director, page 2 should be	틸	1 Natural	5 Pend	(Month	1, Day,Year) 2—10—12		· · ·	Yes 2 X			took		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	29a. Certifier (Check only one) 2	CertifyIng Pi	nysician: To the bearing	of examination a	ge, death occu	rred at the time, o	date and pla	ace, and due	to the caus	se(s) and man	ner as state	ed.
Son Wit	Me	29b. Signature and t		and manner s	tated.			nse number		1111			nth, Day, Year)
,		11	1	1 11	M			.M.E.			Decembe		
	+	30. Name and addre	ss of person	who completed caus	se of death (Item	n 23a)							
P		Melissa Bras	sell, MD	Assistant Me	dical Examir	ner 900 V	/. Baltimore	Street, B	Baltimore,	MD 2122	23		

State 31. Date filed (Month, Day Year) JEC 2 7 2012 Registrar

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ∠ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BURLOCK Physician/ 7EORGE 2015 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1636 Wall Drive Pasadena <u>Anne Arunde</u> 5. Social Security Number 8. Date of Birth (Month, Day, Year) 04-07-1940 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Director 218-36-4589 72 1 X M 2 □ F Maryland permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be netitied at once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Pasadena Anne Arundel 1 ☐ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1636 Wall Drive 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black, White, etc. 1 Never Married 2 X Married **会** 1X Yes 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify.White If Yes, Give Year or Dates. 1958 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Millwright Bethlehem Steel Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည George E. Burlock Sr. Amelia E. Jeppi 19a. Informant's Name/Relationship (Type, Print) Loretta Burlock (wife) 19b Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 1636 Wall Drive Pasadena, maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Meadowridge Mem. Park 12-21-2012 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Signature of Funeral Service Licensee Ash 1 e y MOT682 22. Name and Address of Facility McCully-Polyniak Funeral Hom 3204 Mountain Road Pasadena, Kelley Home, P.A. ena. <u>Marvland</u> 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Poset and Peath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physicien: The lew requires that the death certificate be executed physiclen end is the burlel-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day s certificete has been signed by lirector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 N 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.
Funeral Director: After this letely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier within 24 ho
To the Fune (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, NNAPOUSMO 11CHAREL EN

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 4180 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HENRY CLAY BOURKE, III 521 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 220-12-7418 Director 87 1 X M 2 D F Jan 27, 1925 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catorsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 717 Maiden Choice Lane, St. Charles 117 21228 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give 1, Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced W 2 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Brooklyn Hardware 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Clay Bourke, Jr. Isabelle Dumphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma M. Bourke (Wife) 717 Maiden Choice Lane, St. Charles 117, Catonsville, Md. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cedar Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/22/12 Brooklyn Park, Maryland 21. Signature of Euneral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237E. Patapsco Ave., Baltimore, Maryland 21225-1856 M00175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CARDIOGENIC Physician/ SHOCK Medical resulting in death) Due to (or as a consequence of): Examiner FAILURE 12445 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events SERSIS Due to (or as a consequence of): resulting in death) Last Physician/Medical PNEUMONIA P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KIDNEY 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 ☑ No Yes 2 No the Hospital or Attending Physician: I thin 24 hours after death. the Funeral Director: After this certified filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) unicalates 2019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CALATA 900 BALTIMORE. ATON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 Year Kenneth 06:15PM . Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore City Baltimore If Under 1 Year If Under 24 Hrs. 5. **2**9 ig Ses 2 i⊻ 8899 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Nov. 09, 1949 Months Hours 62-8893 63 Baltimore, MD. Director 1**X** M 2 □ F 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10b, Count 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Baltimore County Cockeysville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 902 Saxon Hill Drive United States 21030 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married à 3altimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: White Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Quality Assurance Elementary/Secondary (0-12) College (1-4 or 5+) 12 Ouality Assurance Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hardy Merrill Cook, Jr. Elizabeth Welborn Frierson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is any injury or other trau Cockeysville, MD. 21030 Mrs. Sarah Margaret Cook / Wife 902 Saxon Hill Drive 20b. Place of Disposition (Name of 20c. Location - City or Town, State Harford County 20a. Method of Disposition

| Date | Date | Comment | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | County | Cou nt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final Respirator Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Pylmonary 10 days Sequentially list conditions, if any, cauing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oil) WRCKS To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit nKopenia Exa resulting in death) Last Due to (or as a consequence of): weeks Physician/Medical eloid Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ 3 in the past 12 months? Day Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed?

Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Prinstolani. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 12/22/2012 Resident Physician 3960633 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. 22 Baltimore, MD arballan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 23a, pt. 11, per phy, 8935 1-10-13 sm.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19, Physician/ Month Maneta C. Castro 2012 7:01 P. M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours November 23, Director 023-60-9045 1 □ M 2 🗓 F 95 Yrs. Philippines 1917 in then "neturel", or items 23e or 28a-f show the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Yes 2 XNo 10e. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code Funeral 2412 Hartfell Road 21093 of America 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. \$ 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 Specify: Filipino 1 Tes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be flied within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Pharmacy Pharmacist Be other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be flie and Mental F Margarita Castro Melecio Castro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 end 2 sh Depertment of Health an Important: If Item 27 Is any Injury or other treu 90 DECEMBER 19, Catherine Genthner/niece 2412 Hartfell Road Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evans Funeral Chapel 1 Burial 200 Cremation 3 Removal from State Sunday, Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.
2325 York Road Timonium, Manyland 21093 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ASPIRATION PNEUMONIA CVA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and s the burial-transit Exami Hospitel or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of): Phystclan/Medicat Records, P.O. Box 68760 68 ettending p IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year 1 Yes 2 ii 9 Unknown is certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Aspiration Pneumonia 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform this certificate 2 🗆 No 1 🗌 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) HOSPICE Hospital: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after deeth.

Funerel Director: After this letely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 20 person who completed cause of death (Item 23a) (Type, Print) **JACKIE** JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State 32. Regist 2012 2 7 DEC Registrar X DHMH 17 Rev 06-2011

2012

MANETA CASTRO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 26, 2012 Rita Patricia Coscia 7:07 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)

Maryland Funeral 8. Date of Birth (Month, Day, Months Days Hours Min 219-18-7421 1925 **Director** 1 □ M 2 □ XE 87 Aug. Usual Residence of Decedent 10b. County or than "netural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 K No Maryland Harford Pylesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4841A Clermont Mill Road 21132 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Church Rectory Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Frank Sebeck Dorothy Tuma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 end 2 shu Department of Health an Important: If item 27 is eny injury or other trau once. Joan Taylor / Daughter 80 S. River Road, Plymouth, North Carolina 27962 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Evans Funera1 "Chapel Dec 28, 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service-BelAir
Revenue Trive Forest Hill, Maryland 21050 21. Signatur L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myocard Physician/ disease or condition resulting in death) Medical Examiner Due to (or a a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed ettending physician end for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Month 5 Other (specify) Year ed by the detached Records, P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 5 autopsy
performed?

1 Yes 2 No To the Hospital or Attending Physicien: The I within 24 hours after death.

To the Funeral Director: After this certificate home of the funeral Director, After this certificate completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Cheseapeako Dr. Bullin, md 21014 31. Date filed (Month, Day, Year) 37. Registrar's Signature State 7 Registrar

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Arthur H. Cohee		S - For State legistrar	tate of Maryla		artment c ertificate c		d Mental		Reg. No. 20	12 4181		
Physician Medical Examine	1	I. Decedent's Name (First, Middanthur H. Coho		r H. Co	hee Jr.			2. Date of De		3. Time of Death 1800 hrs		
		a. Facility Name (if not instituti 12316 Ridgely Road	on, give street end nu	mber)		4b. City, Town, or Ridgely	Location of De	eath	4c. County of Caroline	Death		
Funeral Director	- 1	220–12–6393	6. Sex	7. Age (In yrs. 89	last birthday) Yr	If Under 1 Year Months Days	If Under 24 Hours		7/1923	9. Birthplace (State or Foreign Country) Marylan d		
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the Maryland s or 28a-f she tiffed at once	000	Maryland Caro Oe. Street and Number		Ric	dgely	10f. Zip Code 21660		J		zen of What Country?		
Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by European Director		12316 Ridgely 1. Marital Status 1. Never Married 2. N	12. Was Dece	12. Was Decedent Ever in U.S. 13. V ed Armed Forces? If			panic Origin?	(Specify Yes or Nerto Rican, etc.)	USA lo- 14. Race - White,	American Indian, Black, etc.		
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215-00 be filed wintal Hygien riked other cent, the M		7. Father's Name (First, Middle Arthur H. Cohe	, Last)		<u> </u>	1	8.Mother's Na	ame (First, Middle	General Maiden Surname)	roous		
MD 21 12 should 1 14 and Mer 157 is man 170	2 1	9a. Informant's Name/Relations Andrea Foster/	ship (Type, Print)		1.7	g Address (Street	and Number	or Rural Route Nu	umber, City or Town,			
MOFE, Pages 1 and of Heal of: If item	2	0a. Method of Disposition Burial 2 Cremation Donation 5 Other S		m State	crematory or of			Date 2/21/201		ity or Town, State		
Balti permit. Departm Imports	2	1. Signature of Funeral Service	Licensee Stephe	nie Ost	er 22. I	lame and Address	of Facility	remetion S	ociety of M	aryland, Inc. yland 21228		
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Division of Vital Records, P.O. Box 6876 To the Bospiral or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the funeral control of the funeral director. Be Completed by Physician/Miedical Certification: To Be Completed by Physician/Miedical Certification:								1 Yes	psy prid primed? dea	ere autopsy findings available or to completion of cause of hith? Yes 2 No		
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To the Hos within 24 h To the Fun completely	((check only Certifying Pi	nysiclan: To the best miner:On the basis of and manner sta	examination a		ion, in my opinion, o	death occurred		and place, and due	to the cause(s)		
		1/1/4	4		111	29c License O.C.M			December 18	(Month, Day, Year) 3, 2012		
		D. Name and address of person Russell Alexander MD Date filed (Month, **Day, Year)	. Assistant Me	•	iner 900	W. Baltimore S	Street, Balt	imore, MD 21	223			
State Registra	4	DEC 2		istrar's Signatu	B. 40	eld.		Cit Ser				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 630gm 2012 Physician/ Month EG67 Medical 4a. Facility Name (if not institution, give street and nun 4c. County of Death **Examiner** PRINCE LEORGES FORESTVIlle REHABILITATION CENTER 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) UNENOW 1 M 2 X-F **Director** 105 VITSINIA Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State **Funeral Director** WaSHINGton 1 √es 2 □ No 10g. Citizen of What Country? Street and Number 2001 JUT ST United STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? ģ 1 Never Married 2 Married more, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BIACK If Yes, Give Year or Dates 3 Widowed 44 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Public TRANSPORTATION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary EllEN MATO FIOYD WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jasmine 1507 BENNING 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition P Burial 2 ☐ Cremation 3 ☐ Removal from State Page 1 + 16N Cemetery 12/22/12 Clinton, MD

22. Name and Address of Facility W Waster CHANES ET FUNE POLISERIES 12/22/12 Ressurection Cemetery ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 10684SoutHEAN MD BIND DUNKINK MD 26754 Molso 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hepatoceilular CARcinoma Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hepatitis DISPASE CHTONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death P.O. | been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> CHRONIC KIDHEY DISEASE 1 🗆 Yes 🔼 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Yes 2 No After this certificate I funeral director, pag To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 51520 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 20032 1328 Southern AVE. SE WASHINGTON, BAHRAM PISHDAD, M.D. 31. Date filed (Month, Day, Year) State DEC 2 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month Physician/ 0:10 Katherine Carter December Ann Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8 Date of Birth Days (Month, Day, Year) 219-18-3155 88 Director 1 □ M 2XXF Baltimore 02-22-1924 permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Haalth and Mantal Hygiane. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any highly or other traumatic event, the Medical Examinar must be notified at once. 10h Count 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Baltimore Nottingham Maryland 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? Funeral 4300 Cardwell Avenue 21236 USA Apt. 203 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify. 3 Widowed 4 ☐ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Clerk Banking Industry Ba 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Merson Louisa Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Kathleen Graff - Daughter 4027 Old Federal Hill Road Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State Parkwood Cemetery 12-27-2012 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Typeral Artice Licensee 5305 Harford Road 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if he art failure. List find one cause on each line. Approximate Interval Between Onset and Death Immediate Ca (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami this certificate has been signed by the attanding physician and ral director, paga 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events or Attending Physician: The law raquires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No |@ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completaly filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifiei Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Signature a d title of certifie 29c. License number 29d, Date signed (Month, Day, Year) ap. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 26 2012 Month Stephanie K. Chase December 4:32 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours **Director** 218-36-3513 1 □ M 2🛣 F 73 12/26/1939 MD ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2610 Liter Drive 21042 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done life. DO NOT use retired) e 1 and 2 should be filed within 72 is of Health and Mental Hygiene.
If item 27 is marked other than "reviousher traumatic event, the Med during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Manager Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Karr Frances Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>James W.</u> Chase - husband Ellicott City, MD 21042 2610 Liter Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If ite
eny injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crest Lawn Mem. Grdn. 12/29/2012 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death LUNG CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DISEASE CHRONIC OBSTRUCTIVE KULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence oi). the attending physiclan and hed for use as the burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🕱 No
9 ☐ Unknown Month Pregnant at time of death the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 20 Other (Specify) HOSPICE 1 Yes 2 🛛 No ဂူ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 2 Accident To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number as MD D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED Q. ABBOS MD 6336 LANE CEDAR OUMBIR 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

12-09760 Brian Patrick Coleman

ease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 2	1.1815
State of Maryland / Department of Health and Mental Hygiene	41010

		1- For State Registrar			Certifica	ate of	Death					Reg. No.				
Physici	an/	1. Decedent's Name (First, Middl	e,Last)							1	Date of Dea Month	Day	Year	3.	Time of Death	
Medical Exami	ner	Brian	Patrick (Colema	n_					1	Decembe	er 22, 201	12		1654 hrs	
		4a. Facility Name (if not institutio 6714 Meadowlawn Cir		ımber)		4t	o. City, To New M		ocation o			Fre	ounty of derick			
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birth	nday)	If Under	_	If Under				11	Foreign	lace (State or	
Director		218-33-8488	1XXM 2F		27	Yrs.	Months	Days	Hours	Min.	Feb.	8, 19	985	Count	ry) MD	
iow any		Usual Residence of Decedent 10a. State 10b. County	roll	10c.	City, Town	or Locatio									Od. Inside City Limits Yes 2 XXNo	
Maryland 28=f show	흱	10e. Street and Number				71117	10f. Zip C	ode				10g. Citizen	of Wha	t Country	?	
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho	I Director	5353 Buffalo					·	217				Unit	ed	State	es	
t be r	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Dec arried Armed F		in U.S.					in? (Spec Puerto Ric	ify Yes or N can, etc.)	0- 14.	 Race - American Indian, Black, White, etc. 			
or it	ᇍ		1 Yes	2 X	No		Yes 2X	₹ N.				Specify: White				
15-0036 filed within 72 hours after a 1 Hygiene. ed other than "natural", o t, the Medical Examiner u	ğ	3 Widowed 4 Div	orced If Yes, Give Yes or Dates:		nd) 16a [ind of wor	k done	16b. Kind		ness/Indi	ıstry	
hour natu	ted	Elementary/Secondary (0-12)		1-4 or 5+)	10a. [use retired					·	
36 iin 72 iin dical	읦	12th	College (140131)		Elec	tric	ian				EI	.ecti	rica.	l Com.	
-0036 I within giene. ther that	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, I									irst, Middle,	Maiden Su	rname)	`		
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	Be										Eliza	abeth	Cole	eman		
21215 21215 buld be file I Mental H marked of	9	Unknown Susan Elizabeth Col 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town												p Code)		
re, MD 21; I and 2 should b Health and Men fitem 27 is mar gr traumatic eve	П	Shane Deithor	n step-	fathe	r	5353	Buf	falo	Roa	ad M	t. Ai	ry, MI	2	1771	7	
ore, ML ssland 2 s of Health a Ufitem 27	- 1	20a. Method of Disposition			20b. Place o	of Disposit	ion (Name	of ceme	etery,		Date	20c. Loc	ation - C	City or To	wn, State	
= 8 8 H E		1 Burial 2 X Cremation		rom State	South	Carr	oll	Crem	nator	y De	c. 29	, 2012	2 Sy	kesv	ille, MD	
		4 Donation 5 Other St. 21 Signature of Funeral Prvice	Licensee			22. Na	me and A	ddress o	of Facility	5	3 11					
Balt permit. Depart Import injury	H	FIRMIN IN	MULLY			Bur	rier	-Que	en l	uner	at Hor	ne & (rem	ator	y, PA	
Physician													Approximate Interval			
/Medical	×4	frillure. List only one cause on each life. Immediate Cause (Final disease a. Heroin and Alcohol Intoxication														
Examiner	V	Immediate Cause (Final disease or a lition resulting in death)	ue to (or as a			IIO1	LIILUZ	ıta	L1011							
		Sequentially list conditions,	b											-		
	힐	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequer	nce of):											
	E	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequer	ice of).									-		
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Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	21	IF FEMALE:		outcome of	pregnancy							23d. E	ate of d	ate of delivery		
687 ertific ding p	au/	23b. Was decedent pregnant in the past 12 months?	I Live	oirth			al death	3	Ectopic	pregnanc	у	Mo	onth	Day	Year	
Box 687 he death certifi the attending	Si			nant at time	of death 5	Othe	er (Specif	y)				1			W)	
he de	Physician	Part II. Other significant condit	9 Unkn		not requiting	n in the un	dorluina	ausa siy	on in Da	rt I	23e Did	tobacco use	contrib	ute to the	cause of death?	
ires that the signed by led detach	Ď		iona continuating t	o deali but	nocresciting	g iii uie uii	ide lying c	ause giv	CITALL	1. 1.		100			ly 4 Unknown	
S, I	Pe	<u>Cocaine Use</u>								_	24a, Was				sy findings available	
ords, tw requir	ped ed										auto		pri		pletion of cause of	
Rec The Is	Completed										1 ✔ Yes			✓ Yes	2 No	
tal Rec	Be	25. Was case referred to medica examiner?					26			Check onl	y one)					
Viting this of 1 dire	2	1 ✓ Yes 2 No	Hospital: 1	Inpatient :	2 ER/O	utpatient			-			Residence			cene	
Division of Vital Records, ral or Attending Physician: The law requiring after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Ξĺ	27, Manner of Death	28a. Date (Monti	of Injury n, Day,Year)	28b. 7	Time of Inj	, ,		at Work			how injury				
ttend ttend tor: / the	cation:	Pend	stigation La I.	2-22-1			pm	-	s 2 📉			ntal c				
or A after of Direct of I in by	ertific	3 Suicide 6 Coul	d not be 28e. Plac	e of Injury -					ilding, etc	c. 28					Route Number, City	
D pital ours	Ö	4 Homicide	rmined (Specify)	То	wnhou	se/Ro	whou	se		N		rket,			Tawn off.	
ne Ho n 24 l. le Fun	g	,	hysician: To the be												ause(s)	
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		miner:On the basis and manner s		ion and/or if	vestigatio				Junea at tr	io unie, uau					
	Σ	29b. Signature and title of certifie	er					License							, Day, Year)	
		Jamel Tushi	ull MD					O.C.M	.E.			Decer	nber 2	3, 2012	<u> </u>	
		30. Name and address of person										24000				
		Pamela E. Southall, M						imore	Street,	, Baltimo	ore, MD 2	21223				
	12.00	31. Date filed (Month, Day, Year)		egistrar's Si	gnaturė	fran	2									
Regis	(cl	NEW X	CUIC KE	ساس	10.	A STATE OF										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 77 Jun Chen 2012 10:15am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery Collingswood Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Months Days Hours Min China 84 Director 095-78-8011 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director Rockville Maryland Montgomery 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20850 90 Monroe Street, #902 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?,
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Asian Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machinery Design Mechanical Engineer permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Radburn Court, Rockville, Maryland 20850 Yuan Chen - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Ft. Lincoln Crematory, 12/19/2012 Brentwood, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility atri Simple Tribute Funeral & Cremation Center Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any adding to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans attending physician for use as the hurial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe page 2 this certificate has 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d, Describe how injury occurred 1 Natural Accident 5 Pending 2 🗌 No 24 hours after death Funeral Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated derlift no Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 □ only one) 29b. Signature and title 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

2401 Research Blvd., #330, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

M.D.

Ahmed Heshmat,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ance D. Cook		State Registrar	te of Maryland	Hygiene	Reg. No. 20	12 4181							
Physicia Medical Exami		1. Decedent's Name (First, Middle, Lance	·	Cook					2. Date of Do Month Decemb		3. Time of Death 0731 hrs		
		4a. Facility Name (if not institution, Johns Hopkins Hospital	-		1	lb. City, Tow Baltimo		ation of De	ath	4c. County of E Baltimore			
Funeral Director		213 69 0060	Sex 7. Ag	e (In yrs. 55	last birthday) Yrs.	If Under 1 Months	_	Hours N	Hrs. 8. Date of I				
with the Maryland ms 23a or 28a-f show any be notified at once,	Director	Usual Residence of Decedent 10a. State MD 10b. County Ba1 10e. Street and Number 1923 Oxley Roa	timore	10c. City	, Town or Locati	on 10f. Zip Co	ide	ndalk		10g. Citizen of What			
rs after death ural", or iten miner must	ed by Funeral	15. Decedent's Education (Specify	1 Yes 2 ced If Yes, Give Year or Dates: y only highest grade com	X No	If You 1 16a. Decedent	es, specify C	No succeptation	exican, Pue pecify: (Give kind		White, e	White		
5-0036 Iled within 72 hou Hygiene. I other than "nath the Medical Exa	Completed	Elementary/Secondary (0-12) 11 years 17. Father's Name (First, Middle, La	College (1-4 or 5	5+)		Wareho	use			Clo	thing 		
ID 21215-0036 2 should be filed within 7 1 and Mental Hygiene. 27 is marked other than matic event, the Medica	To Be C	Jay Emory Cook 19a. Informant's Name/Relationship	- 12-14-12-12-13-13-13-13-13-13-13-13-13-13-13-13-13-		19b. Mailing	Address (Audre	y Louis		State, Zip Code)		
≥ p = s		Bruce A. Cook 20a. Method of Disposition 1 ABurial 2 Cremation	Brother	20b.	Roa of cemete		indalk, i ecember 28, 2012	Md. 21222					
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Spec	eify:		lly Hil					f Dundalk, Dundalk,	River,Maryland		
Physician), ()	23a. Part I. Enter the disease or confailure. List only one cause on	Approximate Interval Between Onset and										
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led Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consect. Due to (or as a consect.							1700			
O, the executed sician and burial - transit	UNPENDED AMENDED									=1.00=1ate			
Division of Vital Records, P.O. Box 6876C the Hospital or Atteoding Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physpletely filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcom 1 Live birth 4 Pregnant at		2 Fet	al death er (Specify)	3E	Ectopic preg	nancy	23d. Date of del Month	ivery Day Year		
S, P.O. urres that the a signed by the detache	ā	Part II. Other significant condition Asthma; Schizophrenia	s contributing to death	but not re	esulting in the ur	nderlying cau	use given	in Part I.	1 Y	es 2 No 3	e to the cause of death? Probably 4 ✔ Unknown		
Division of Vital Records, P.O. ral or Atteoding Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Completed								1 ✓ Yes	opsy prior formed? deat	e autopsy findings available to completion of cause of h? Yes 2 No		
Vital I hysician: this certifi	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 🔽	ER/Outpatient				ck only one) sing Home 5	Residence 6 0	Other:		
ion of teoding Pheleath. tor: After tors the funeral		27. Manner of Death 1 V Natural 5 Pending 2 Accident Investig		ry ear)	28b. Time of In	· .	Injury at			e how injury occurred			
Division To the Hospital or Atteod within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could nudetermin determin 29a. Certifier	ot be 28e. Place of Inj	ury - At ho	ome, farm, street	, factory, offi	ice buildii	ng, etc.	28f. Location or Town,		r Rural Route Number, City		
To the Hos within 24 h To the Fur completely	edical	(Check only 1 Certifying Phys	iclan: To the best of my ner: On the basis of exam and manner stated.										
F > F 3	Me	29b. Signature and title of certifier	and marrier states.				29c. License number O.C.M.E.			29d. Date signed December 22			
		30 Name and address of person wh Ana Rubio M.D., Ph. D.	o completed cause of de Assistant Medic	al Exan	niner 900		ore Sti	reet, Bal	timore, MD 2	1223			
Sta Regist		31. Date filed (Month, Day, Year) NFC 2 7 201	2 Agentar	's Signatu	parke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 | 8 | 8 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ciarpella 2012 P^{M} 1:13 Medical Decembei 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Edgemere BAltimore 7908 Shore Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 219-22-2805 XXM 2 □ F 85 Yrs. October 12, 1927 Maryland iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21219 USA 7908 Shore Road 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Ares 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: "natural", Specify: 3 Nidowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Brick Layer Construction 12 years Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Ciarpella Concetta Rumando 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Ciarpella son 7908 Shore Road, Edgemere, Maryland 21219 Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 27 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale, Maryland Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 2012 signature of F Service Lices Connetiveral Home of Dundalk,P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Canco disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year Yes 2 No g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obstructive ownonwy 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu death. ☐ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO055157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAREN Point BALANSON North Fort Howard MD 21052 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar √ DHMH 17 Rev 06-2011

12-09666 Brian Casey Coe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brian Casey Coe	State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death 2012 418	(
Physician/	Registrar Reg. No. 2 0 1 2 7 1 0 1 1 1 Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death	-
Medical Examine		
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	-
Director	$219-15-9929$ $_{1[X]M}$ $_{2[F]}$ 30 $_{Yrs.}$ $\frac{Months Days Hours Min.}{May 27, 198}$ $\frac{Foreign}{Country}$ Mass	
	Usual Residence of Decedent	
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yland Lonce	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	-
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212 rould b d Meni d Meni fic eve	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	Ī
MD d 2 sho lith and n 27 is	William A. Coe / Father B108 Philadelphia Rd, Abingdon, MD 210 09	
Baltimore, Nemit. Pages I and Department of Health Important: If item aljury or other trau	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Date 20c. Location - City or Town, State crematory or other place) 20c. Location - City or Town, State 2 Cremation 3 Removal from State 2 Crematory or other place)	
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Baltimo permit. Page Department of Important: injury or oth	21. Sign the of Fuyera Service Coensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, MD 21001	
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To the How within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
H 2 H 2		
	O.C.M.E. December 20, 2012	
21/1	30/ Mame and address of person who completed cause of death (yem 23a) Pursoll Alexander MD Assistant Medical Examiner 900 W Raltimore Street Baltimore MD 21223	Т
U. State	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	_
State Registrar	11-11-2-7-7(117-1-7) # # # # # # # #	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death rea Physician/ arles 12 Month 2^{Day} 2012 8:30 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 307 Ouaker Bottom Road Havre de Grace Harford 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 215-84-358 Director 1 M 2 □ F 1960 Maryland 10/20 Usual Residence of Decedent itam 27 is marked other then "netural", or itams 23e or 28a-f show other treumatic event, the Medical Examinar must be notified at filad within 72 hours after death with the Maryland 10c. City. Town or Location 10d, Inside City Limits Director Maryland Harford Havre de Grace 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21078 307 Quaker Bottom Road U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceded Law Armed Forces? 1978

12 Yes 2 No 1980 14, Race - American Indian, Black, White, etc 1 Never Married 2 M Married ģ Baltimore, Maryland 21215-0036 Specify White If Yes, Give Year or Dates. 1 ☐ Yes 2 🕅 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Paga 1 and 2 should be filed within 72 t. Department of Health and Mantal Hygiane. Importent: If itam 27 is marked other then "ne eny injury or other treumatic avent, the Mantal 2009. (Give kind of work done during most of working life. DO NOT use retired)

Auto Body Tech. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Automotive 1 Ó Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles A. Cregar Lollie Mae Lenier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Quaker Bottom Rd, Havre de Grace, Joan Cregar Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State West Chester, Pennsylvania Ferris & Co. 12/26/12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funda Service Lig Funeral Home, P.A. Tarring Address Facility Aberdeen, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician aslatu disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, healing to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ata has baen signad by the attending physiclen and pege 2 should ba detached for use as the burlal-transit or Attanding Physicien: The law requires that the death certificete be axecuted that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 🗍 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of cartificata has autopsy 1 ☐ Yes 2 ☐ No filled in by the funaral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(\frac{5X}{2}\) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral DI complately filled in Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ruch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 Blud aven

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Da May Colbert 2012 8:54 P M Frances 18 Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Hospital Center Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Director 1 □ M 2🗓 F 213-24-8106 Yrs. 84 Dec. 30, 1927 Maryland Usual Residence of Decede filed within 72 hours even and Hygiene.
ed other then "naturel", or items 23e or 28e-f show es event, the Medical Experiment must be rectified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Carroll Maryland Keymar ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2059 Keysville-Bruceville Rd. 21757 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 ☐ Yes 2 ☑XNo If Yes, Give Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. 3 ₩ Widowed 4 □ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) shoe factory inspector treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file end Mentel H Is merked o မ Flora Belle Otto Charles McKinley Spielman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 1 end 2 s of Heelth item 27 l Susan Reese/daughter 2059 Keysville-Bruceville Rd. Keymar, MD 21757 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Importent: If it eny injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky Hill Cemetery 12/21/2012 nr. Woodsboro, MD Signature of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home, P.A. athanne Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Sepsis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 48 hours rforated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) physician end s the burial-transit or Attending Physicien: The lew requires that the deeth certificate be executed Exar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N certificate 2 🗆 No 1 Yes of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Other: 2 No 1 Tes npatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funerel Director: After this a completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation
6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1/Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) AN D61207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Memorial Sabuhi 31. Date filed (Month, Day, Westminster MD 21157 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December Lawrence J. Cieslak 4:20P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7346 Greenbank Middle River Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthday) Funeral Months Hours Mar 23 214-38-9320 73 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Md. Baltimore Middle River 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7346 Greenbank Road 21220 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 2 should be filed within 16....th and Mental Hygiene.
27 is marked other than "natural", or by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Harris Fire (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Protection Company President traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edward F. Cieslak, Helen Pawlak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Coreen Cieslak - Wife 7346 Greenbank Road Middle River, Md.21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 X Burial 2 Cremation 3 Removal from State St.Stanislaus Cem 29,2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses 1201 Dundalk Avenue Baltimore, Md.21220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on a chiline. ying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical s a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Due to for as a non-sequence of Exami and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? Yes 2 No certificate 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 XNo ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 101 29b. Signature We December 27,2012 5x1 Name and address of person who completed caus

State Registrar

DHMH 17 Rev 7/2009

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32. B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Physician/ 1725 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Nedical Center MI mo/e 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) (Month, Day, Year) Director 1 M 2 D F and 2 should be filed within 72 hours after death with the Maryland i Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Experience must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UISIA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Specify: PLAC 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematery or other pla Date 20c, Location - City or Town, State Page 1 6 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licen. Name and Address of Facility 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in leart failure. List only one cause on each line.

Immediate Value (Final Approximate Interval Between Onset and Death Physician/ -ntracran disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): sate has been signed by the ettending physician and page 2 should be detached for use es the bunel-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has 1 Yes or Attending Physician: **Division of Vital** completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Natural 2 Accident injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my reliable death occurred. 29a. Certifier (Check Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and th 29d. Date signed (Month, Day, Year) 74432 12-22-2012 nd address of person who completed cause of death (Item 23a) (Type, Print) M,D. St Beat Greene Baltimore, MD Narlin 21209 DEC 2 7 2012 31. Date filed (Month 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's ame (First, Middle, Last) 2. Date of Death Physician/ OHN LOPEIN. Year 2 32 Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death
ANN AXUM 140 801 ASHINA M (stewn townue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 216-34-1677 Hours (Month, Day, Year) Director 1 X M 2 D F 75 April 5, 1937 Maryland I Hygiene. other then "neturel", or items 23a or 28e-f shovent, the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 McKinsey Park Drive, Unit 104 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black White etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🗵 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Northrup Grumman Corp. Contrct Negotiator permit, Page 1 and 2 should be filed w Department of Health and Mentel Hygi Importent: If Item 27 Is marked othel eny Injury or other treumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John M. Clopein Caroline Henrietta Viehmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Joan Clopein (Wife) 602 McKinsey Park Drive, Unit 104, Severna Park, Md. 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 12/29/2012 Glen Burnie, Maryland Atlantic Crematory, LLC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Fcker 22. Name and Address of Facility McCully-POlyniak Funeral Home, P.A. 1 3204 Mountain Rd., Pasadena, Md. MO0175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Thuit Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed ettending physicien end for use es the buriel-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Month 5 Other (specify) Day ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed irector, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA မ After this funeral dir Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No NA within 24 hours after death

To the Funerel Director: A

completely filled in by the I Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) NA Medical 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) HEADONINGE RUAN EIKINGE HOZION 30. Name and address 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ encia Dept Medical 4a. Facility Name (if not institution, give street and pumb Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE 2130 CHANTILLA RD. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Director 227-94-8943 1 M 2 🗓 F Yrs 54 VIRGINIA MAY 19 1958 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director or 28a-f 1 ☐ Yes 2 🛛 No BALTIMORE BALTIMORE MARYLAND 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21228 U.S.A. 2130 CHANTILLA RD. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ٥ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 SpecifyAFRICAN-AMERICAN 1 ☐ Yes 2 X No Specify: should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MAINTENANCE/STOCKER WALMART other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HORACE W. DUGGINS PLUMMIE **TYNES** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau 2130 Chantilla Rd., Baltimore, Md., 21228 <u>Valerie Duggins/Sister</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) ZION CEMETERY 01-05-13 LANSDOWNE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Lellen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreatic cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day ed by the a detached f Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an s certificate has build director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number Ushajapanemo D0057-465 12/24/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmort MD Z1209 NSKAjapaksemo 2835 Smith N 1203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

P.O. Box 68760

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month EMILE 0:06 AM DUPONT DELL MEGO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HUSFITA NORTHWEST RANDAUSTONN BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min. 1 XM 2 □ F 91 Yrs Massachusetts **Director** 018-03-9729 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified to once. 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Gwynn Oak 1 Yes 2X No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2317 Poplar Drive 21207 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 194

If Yes, Give 10/4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, orces? 1943 Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. 1945 Completed 3 XWidowed 4 ☐ Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Atlantic Richfield Co. Office Work Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Noah Dupont Rosalda Boucher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Salomon Daughter 2317 Poplar Drive Gwynn Oak, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 12/26/12 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor ^{22 Name and Address of Facility} Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 23a. Part 1. Enter the disease, or compile tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final LARDIOVAGEVIAR Physician ATHEROSCUERNTIL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 V N 1 🗌 Yes 2 🗹 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 M No ျ 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man r of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier DECEMBER 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILLAEL 5401 COURT ROAD MD OLD 31. Date filed (Month, Day, Year) 32. Registrar Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #1 per PHY G935 1/08/2013 JH

State of Maryland / Department of Health and Mental Hygiene
amend #19a Per ANA BD G935 1/09/2013 JH

Certificate of Death

Reg. No. 2012 1 - For State Registrar Decedent's Name (First, Middle, Last)
Harry Joseph DeVenny 2. Date of Death 3. Time of Death Physician/ Month Day Year Harry Joseph DeVenney Medical December 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5018 E. Oliver Street Baltimore 5. Social Security Number If Under 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign Year If Under 24 Hrs. **Funeral** Months Hours Min July 16, 1930 Virginia Director 212-26-7058 1 X M 2 D F Yrs Usual Residence of Decedent 28a-f show 10a, State notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code ms 23a or must be n Funeral 5018 E. Oliver St. 21205 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner rmed Forces?
X Yes 2 No 1946-Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 'natural", Specify: 3 Widowed 4 Divorced 1952 Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 12 2 laborer construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Harry Oswald Inez Thompson other traumatic 19a. Informant's Name/Relationship (Type, Print)

Ethel M. BeVenney -Department of Health and Important: If item 27 is n any injury or other traums once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 5018 E. Oliver St; Baltimore, MD 21205 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Ronald S Vade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons and Death Immediate Cause (Final Physi i n years tsophagea disease or condition resulting in death) Medical Examiner Due to (or a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No the g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law page 2 s has autopsy perform certificate 2 No ☐ Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) Other: 4 ☐ Nursing Home 5 Presidence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 12-13-12 NO Me Cormack J. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharen Frederick RO Boltimore 0/0 - SYP 18 2/229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ 11:00A M Medical cility Name (if 19)t institution, give street and number, Examiner 4c. County of Death ElKridge lowanberry Drive Howard If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 D F **Director** 22 MDitem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10b. County Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** Kridge 1 Yes 2 No toward 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event. If a Medical Examinar must be 21075 USA Trne Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 3 1 Never Married 2 Married 1 ✓ Yes 2 ☐ No If Yes, Give Completed by 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO 1001 use retired) dhdary (0-12) College (1-4 or 5+) ter K Be Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma ဂ္ Domus 19b. Mailing 20a. Method of Disposition Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 12 27 Brookly 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee V. Ces Ba 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the attending physician and ched for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month 5 Other (specify) To the Hospital or Attending Physician: The law requires that the oea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached formula the funeral director. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Appenden Sion Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 301+ 1 ☐ Yes 2 ☐ No Yes 2 7Ne 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 W No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) 2-26-12 (1)9977 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 419 W Redwood Bu la mous MA J Domenici (1) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:00 am Grace Marie DiPaolo December 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kensington Park Retirement Communitu Montgomery Kensington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Director 032-18-6972 1 □ M 2 🗓 F 85 09/28/1927 Massachusetts Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f should may injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10d. Inside City Limits 10a, State Director 1 X Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 2006 Prichard Road 20902 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify. 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grace Elizabeth McDonald Henry Francis Bilodeau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4328 Kennedy Street, Hyattsville, Maryland 20781 Silvia M. DiPaolo - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 12/29/2012 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licenses And Wichterbursiles 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Colon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Day Pregnant at time of death g Unknown 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Cappany \(\text{Nursing} \) ည 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number December 26, 2012 D26259 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Avenue, #103, Bethesda, Maryland 20814 Ava Kaufman, M.D., 31. Date filed (Month, Day, Year) OEC 2 7 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 41830 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1355 M MOIZU Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death ltose un MUDSTAR HARBOR BALMORE N/A Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 226 34 5596 Hours (Month, Day, Year) Director 1 □ M 2 🗓 F 82 Virginia 09/19/1930 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1509 Elmtree Street 21226 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Boles Georgia (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Dorsey / son 1509 Elmtreet Street Baltimore, Maryland 21226 Baltimore, Important; If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State 12/29/2012 Bayview Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ONGESTUD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ARDINE Sequentially list conditions, if any leading to inmodiate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exemithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 🗌 No 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 2 🗆 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 3950 4/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIZIS TOP LIVE 3001 S. HAnoven St. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Frieda Anna Doxzon Medical December 2012 3:20 P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Months Hours Min. (Month, Day, Year, Director 097-20-9378 1 M 2 X F 84 Usual Residence of Decedent 21, 1928 New York ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Carroll Maryland New Windsor 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3302 Hawks Hill Rd 21776 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>۾</u> 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Completed Specify Year or Dates White 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 other t bookkeeper necktie mfq. Be 17. Father's Name (First, Middle, Last) and Mental F 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil trment of Health and Mental rtant: If item 27 is marked i jury or other traumatic ev Edwin John Huebner Marie Coogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Bowie/daughter 3302 Hawks Hill Rd. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 12/23/2012 All County Cremation Sykesville, MD 21. Signature of Füheral Service 1 22. Name and Address of Facility Hartzler Funeral Home, P.A. New Windsor, MD 21776 Box 249 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ause (Disease or Trijury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months? Pregnant at time of death Month Dav Year detached g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably A ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas After this certificate performed? 2 🗆 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? within 24 hours and To the Funeral Director: After this or analytical filled in by the funeral director. ၉ 1 Tes 2 \No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 0 30. Name and address of person cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41832 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ Edwina Weston - Dyer 2012 4:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis Springbrook Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/12/1932 **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 1 F Director 094-26-7100 80 New York Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examinar mest be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9895 Palace Hall Drive, Apt. 313 20723 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X☐ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) t. Page 1 and 2 should be filed with trument of Health and Mental Hyglentant: If item 27 Is marked other 1 jury or other traumatic event, the Historian Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Timothy Weston Mae Ratliff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2210 10th Avenue, Apt. 307, Oakland, CA 94606 Adam L. Dyer / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page Department o Important: If any injury or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/23/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final chysician/ disease or condition resulting in death) Acute Cardiorespiratory Failure Medical Due to (or as a consequence of): Examiner Chronic Kidney Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): inding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Advanced Dementia that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the for use as the buria Physician/Medical d. Coronary Artery Disease Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Ectopic pregnancy Month Day 5 Other (specify) Year page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 24 hours after death.

Funeral Director: After this certificately filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, D 63232 12.21.2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Gomez, M.D. 15245 Shady Grove Road, #310, Rockville, MD 20850 31. Date filed (Month, Day, Year)

DEC 2 7 . Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend 20b-c, per me, g934 12-27-12 sm
State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19^{Day}2012^{Yea} Floyd (NMN) Elliott Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Silver Spring MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min. Hours 578-60-1926 Country) Director 1 🔀 M 2 🗆 F 64 Yrs. Usual Residence of Decedent 09/23/1948 Wash.,DC permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show well jujuy or other treumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Washington D.C. 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 124 Elmira Street S.W. 20032 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PEPCO 12th Lineman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Elliott Lois Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shiron Elliott-wife 124 Elmira St., SW Washington, DC 20032 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place)
Lington National 12/31/2012 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Triangle VA 4 Donation 5 Other (Specify) Arlington, 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 4594 Beech Rd Freeman Funeral Services TempleHillsMD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). cate has been signed by the ettending physician end page 2 should be detached for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 No Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Department 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No the Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signaturejand title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ddress of person who cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25, per me, g935 1-17-13 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Belva A. Eaton Physician/ Month 2012 02:50 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harrford County Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Days 579-10-6944 92 07/19/1920^{ear)} Washington, D.C. Director Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford County Rising Sun 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 240 Codjus Drive 21911 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2. 2. No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married → ○ 3 5 ○ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed 3

▼ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Calibrator Pendix other Be 18. Mother's Name (First, Middle, Malden Surname)
Maude L. Stone 17. Father's Name (First, Middle, Last) Frank A. Berder Jf Health an.
• item 27 is man.
• traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Eaton (Son) 2118 Bellvale Road, Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Faith 12/29/2012 Rosedale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 Fan 8 Legn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Sepa Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, 0 Examine Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): MEDICAL EXAM Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Director: After this certificate 1 Yes 2 No 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this Attention Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 X Yes 2 1 Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Compatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ceptili 29d. Date signed (Month, Day, Year) 00068014 MD 12/25/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPPER CHESAPEAKEDF, BELAIRMD - 21014 J. HUB 31. Date filed (Month, Day, Year) 37. Registrar's Signature State Registrar OHMH 17 Rev 7/2009

Shirley E. Ewell State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **DEC** Day 2012 Year 10:09 AM Physician/ 23 217:01 Ex Medical 4a. Facility Name (if not institution give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Manor Care Roland Park Baltimore City N/A Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F 212-30-7622 77 MAR 19 ay, 1935 Maryland Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified MD Baltimore 1 Tes 2 No Reisterstown 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21136 414 Shirley Manor Road USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ori þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced "natural" Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Practical Nurse Health Care / Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o မ George Thomas Florence Cornish and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Sandra Dutton, daughter 414 Shirley Manor Rd. Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State Metro Crematory, Inc. 12/24/12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) ation 5 Other (Specify)

of Funeral Service Lipens of Stephanie Custer

22. Name and Address of Facility Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician/ dionypopathi disease or condition resulting in death) Medical Due to (or as a consequence Examiner CVA Sequentially list conditions, if any, leading to immediate cases. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) dioheral To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Yes ours after death. eral Director: After this certifica filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 Wo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Investigation Could not be 1 Yes 2 🗌 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D7332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 11:30 ам 201°2 Ferdinand Christian Eitemiller Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lighthouse Senior Living Ellicott City Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days (Month, Day, Year) Director 217-16-4744 1 X M 2 □ F 93 Yrs 1919 June 14 MD parmit. Page 1 and 2 should be filed within 72 hours effer deeth with the Meryland Department of Health end Mentel Hyglene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28a-f show eny injury or other treumetic event, the Medical Exercise. 10a. State 10b, County 10c. City, Town or Location 10d Inside City Limits Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3100 N. Ridge Road 21043 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian was Decedent Ever in U.S. Armed Forces? 1 \cancel{K} Yes 2 \square No \cancel{WWII} If Yes, Give Year or Dates. Black White etc. 1 Never Married 2 Married ģ 1 Yes 2 XNo Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HVAC foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ferdinand Christian Eitemiller Sr. Carrie Dietz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rabeth Eitemiller (spouse) 3100 N. Ridge Rd., Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) entombmen Crest Lawn Mausoleum 12-28-12 Marriottsville, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Haight Funeral Home & Chapel Dauge Saught Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death neumoni'a Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospitel or Attending Physicien: The lew requires that the death certificate be executed 24 hours efter death.

Funeral Director: After this certificate has have already have a managed by the control of the control of the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been already by the certificate has been alr After this certificate hes baen signad by the attending phyelcien end funeral director, page 2 should be deteched for use as the burlel-trensit Cause (Disease or mjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No burs efter death. erel Director: After this certifice filled in by the funeral director, i å 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify Assisted Live 1 ☐ Yes 2 ☐ No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Investigation ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Land Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place and due to the cause(s) and manner stated the time, date and place and due to the cause(s) and manner stated the time, date and place and place are the cause(s) and manner stated the time, date and place are the cause(s) and manner stated the time, date and place are the cause(s) and manner stated the time, date and place are the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fl (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number WD of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 33 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death entis Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peartree Assisted Living Pasadena Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 212-05-1611 (Month, Day, Year) Director 1 M 2 F 98 April 20,1914 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 185 Park Road 21122 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give ≥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 I Hygiene. other than "natural", 1 ☐ Yes 2 🖾 No Specify: 3

Widowed 4 □ Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A C&P Telephone Operator 0 permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumout. other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Gertrude Marie Klump Harry Harris 19a. Informant's Name/Relationship (Type, Print)
Jean C. Mitchell (niece) Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code)
Whitby Lane Camden, Deleware 19934 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Hill Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 12-20-2012 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ashley 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Kelley M01682 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Inset and Death shock, or heart failure. List only one cause or CARMOUNG Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated over the Due to (or as a consequence ory: Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. I have seen that the attending physician and retely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 6 Living ၉ 1 🗌 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Funer completely fil only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 22 2:25 PM 20°112 Dorothy Louise Fitzhugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) Director 215-32-1104 Mary1and Yrs 05/20/1934 show 10a. State 10c. City, Town or Location ir then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Md. Carrol1 Sykesville 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 USA 288 Carnies Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married <u>ک</u> Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h. Des artment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "ns any injury or other traumatic event, the Madio once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 3yrs Elementary/Secondary (0-12) Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Earl Messerschmidt Catherine L. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 288 Carnies Lane Sykesville, Md. 21784. Gordon Fitzhugh (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven 12/26/2012 Glen Burnie, Md. 21. Signature of Funeral Service License ²². Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville,Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical Examiner resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examin Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours efter death. Funeral Director: After this certificate has been signed by the attending physicien and physicien and is the burial-trans that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No thin 24 hours efter death, the Funeral Director: After this certific mpletely filled in by the funerel director, 25. Was case referred to medical examiner? Division of Vital Be B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 To the comple only one) 29b. Signature and title g 29c. License number

State Registrar 21157

Alay Behari M.D. - 200 Memorial Ave., Westminster, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Bay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	aryland	•	artment of H		and M	ental Hy	giene	010	3 1	000	
	1 - State Registrar Certificate of Death Reg. No. 20												14	839	
	Physicia	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day										Year	3. Time	e of Death	
~	Medic	al	Jesse 1	2 Lane			17	7012		15 PM					
	Examin	er	4a. Facility Name (if not institution, g	ve street and number)	4b. City, Town, or	Location o	f Death		4c. Cc	ounty of Death	\ (
	Funeral		5. Social Security Number 6.		e (In yrs. last	birthday)	If Under 1 Year	If Under 2	24 Hrs.	8. Date of Birt	h	9. Birth	place (Sta	e or Foreign	
	Director		214-58-4660	¹X M 2 □ F 61		Yrs.	Months Days	Hours	Min.	June 2	4 , Year) 195	51 Cou	nplace (Stai ntry) VA		
	T OM		Usual Residence of Decedent 10a. State 10b. County		40- Oit T		-11							0	
	ryland -f sh ied a	턍	7	D.		Town or Loc								e City Limits Yes 2√ No	
	r 28a notif		FL India 10e, Street and Number	n River	Ve	ro Be	ach 10f. Zip Code				10a Citizo	n of What Cou		res ZX No	
	with the 23a of st be	Funeral Director	201 Beachside D	rive			329	163			Tog. Citizei	US	-		
	ems er mu	ığ	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of His	spanic Orig	in? (Spec	ify Yes or No-	14.	. Race - Ameri			
9	fer de , or it	ρ	1 Never Married 2 XMarried	Armed Forces? 1 Yes 2 If Yes, Give	No		Yes, specify Cubar		Puerto R	lican, etc.)		Black, White,			
8	rurs at tural" al Exa	Completed	3 Widowed 4 Divorced	Year or Dates.							Spe	ecify: W.F.	ite		
15-	72 ho n "na Nedic	nple	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) life. DO NOT use retired)							g	16b. Kind	of Business Ir	ndustry		
21215-0036	led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4 or 5	(+)	commur	ications	tech	nicia	an	comm	unicat	ions		
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Maryland	ould be file d Mental I marked o matic eve	욘	Jesse Frazier Margaret												
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9 X 6	death certifica e attending phed for use as the	ian/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnanc	у			23d. Date of Month		delivery Day Year				
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P.O.	The law requires that the deate has been signed by the page 2 should be detached	by Pr	Part II. Other significant conditions	contributing to death by	ut not resulti	ing in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of	of death?	
	uires n sign	ed b								1 🗆 '	Yes 2 🔀	No 3 ☐ Pro	obably 4	Unknown	
Sor	aw rec as bee 2 sho	Completed								24a. Was autop		24b. Were auto	opsy finding	gs available of cause of	
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Division of Vital Records,	Physician: The law in this certificate has the director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Deat							
Σ	Phys this cral dir	1	1 Yes 2 No 27. Manner of Death	1 Inpatie		R/Outpatien Bb. Time of	t 3 DOA 28c. Injury	4 De Nu		ne 5 🗌 Resid 8d. Describe h			(y)		
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	To th withir To th comp		29b. Signature and title of certifier	117		-5	29c License	number			20d Date e	signed (Manth	Day Voarl		
			- wood			_	V3	484	7		Dece	mber	170	2012	
3			30. Name and address of person who Williams. Tour			3a) (Type, P	rint) ty Rd	E1.	ders	bus	MD	217	84		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ December 19, 2012 14:22 Stacy J. Freeman Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death <u>Anne Arundel Medical</u> Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/26/1944 9. Birthplace (State or Foreign Country) Tennessee 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🛣 F Days Hours Min Director 68 215-40-9989 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10h County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland | Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1700 Coale Lane 21032 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 🗓 Widowed 4 🗆 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transit Truck Stop Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Durkee Kathleen Holliday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Coale Lane, Crownsville, Maryland 21032 Dennis Coale, Jr./ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date irial 2 🕅 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 5 Other (Specify) 12/24/2012 Catonsville, Maryland 4 🗆 🗆 Metro Crematory 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy, SE, Glen Burnie, Maryland 21061 21. Signatu 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition COPD Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year Pregnant at time of death 5 Other (specify) Day ed by the a detached f 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Diabetes mellitus 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗶 No 1 Yes Other: 0 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending s after death.

I Director: Af
d in by the fu 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

within 24 hor To the Fune completed fil

Adil Degani, MD, 2000 Medical Pkwy, #607 Annaplois, Maryland 21401 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

callette

29b. Signature and title of certifier

State Registrar D73909

29d. Date signed (Month, Day, Year)

12/19/2012

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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 1 3 X Widowed 4 Divor	Married Armed 1 Y	ecedent Event Forces? Forces? Ses 2 X N Give r Dates.	er in U.S. 13	Was Decedent of H If Yes, specify Cub		ecify Yes or No Rican, etc.)		. Race - Ame Black, White pecify: Wh	e, etc.			
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68760 pertificate be	ding pl	/Me	IF FEMALE:	23c. If yes,	outcome of	pregnancy				IFICATION APPR	OVE				
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of one	h. After this certific funeral director,	ate:	27. Minnor of Death 1 ☐ Natural 5 ☐ Per	28a. Da	ate of injury Ionth, Day	28b. Time of injury	worl	⟨? 1	/ 1	28d. Describe	how injury or	ccum e c	out of		
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Oivis alor A	s after Direct		4 ☐ Homicide det	ermined 20e. Pla	ilding, etc. (- At home, farm, si Specify)	met, factory, office			28f. Location (City or To	wn, State)	[7]02 4 D	THATCHER COU		
Hospit	within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral director.	Medical	(Check_ 2 Medic	ring Physician: To the	basis of exa-	mination and/or inve	stigation, in my opini	on, death or	place, ar	nd due to the o	ause(s) and and place, ar	manner as st	cause(s) and manner stated.		
To the	within To the	Σ	only one): 3 La Certify 29b. Signature and title of cert	ring Nyrse Practition	nent of the b	est of my knowledg	e, death occurred at 29c. Licens		te and pla	ce, and due to		and manner a signed (Month			
			1) - (CA	100h	<i>></i>	MO	D	56	0	30	1	1/20	0/12		
7)			30. Name and address of pers	on who completed of	ause of dea	th (Item 23a) (Type,	AKIS	Smi	2						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 20 NANCY SHERIDAN DEMPSTER FRANK 2012 6:20 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 220-40-2014 Hours Director 1 □ M 2**X** F 70 Sept 15, 1942 Maryland 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8221 Thornton Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 3 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Honemakec Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Summerfield Demoster Nancy Riede 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8221 Thornton Road, Towson, Macyland 21204 item 27 Richard S. Frank (Husband) Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
important: if ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 12/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 21. Sign W. The Selection 2. Lawson MITCHECK WIEDUTELD FUNERAL HOME, 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Chronic Obstructive disease or condition Wee Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: ettending physician and for use as the burlal-transit Hospital or Attending Physician: The lew requires that the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Pregnant at time of death ours after death. eral Director: After this certificete has been signed by the e filled in by the funeral director, page 2 should be detached : Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Carcinoma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours To the Fune completely fi 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Raller 1)20907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chatham 31. Oate filed (Month, Day, Year)-

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ROMA M. FORMAN 1:41 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Powerback Rehabilitation Baltimore 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/03/1932 **Funeral** 9. Birthplace (State or Foreign Days Hours New York Director 1 M 2 KF 109-24-7031 80 Yrs Usual Residence of Decedent r then "neturel", or Items 23e or 28e-f show the Medical Examinar must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-f showeny Injury or other traumatic event, the Medical Examinar must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No NY East Norwich Nassau 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Split Rock Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ş 1 ☐ Yes 2 1 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Healthcare** Medical Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Moe Fishler Jeanne Balsam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6841 Caravan Court, Columbia, MD 21044 <u> Wendy J. Appleby / Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/27/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donatail Marshell Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician MO CHOLANG 10 CARCING MA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts.) Examiner Due to (or as a consequence of): sate hes been signed by the ettending physicien and page 2 should be detached for use es the buriel-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

erel Director: After this certificate hes lifilled in by the funeral director, page 2: autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 N Other (Specify) REHAV 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 624 hours a To the Hospital
within 24 hours a
To the Funerel I
completely filled Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 029301 till 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 LUTTERVILLE BRIGHTFIELD POWERBACK REHABILITADOW RO 515

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 Physician/ 05:15P DECEMBER 20°1′2 DANIEL FREEDMAN Medical C 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE Examiner FREEDM WOODHOLME GARDENS ASSISTED LIVING BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 0472671931 Country) **Director** 214-26-7752 1 **X** M 2 □ F 81 10a. State 10b. County or health and Mental Hygene.
Item 27 is marked other than "natural", or items 23a or 28a-f sho other than and the Traminer must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director N/A **BALTIMORE** MD WX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 111 HAMLET HILL ROAD, #1108 21210 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Completed by WHITE 1 ☐ Yes 2 No Specify: 3 Divorced Specify. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BROKER 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) REAL ESTATE nd Mental Hygier Be 18. Mother's Name (First, Middle, Maiden Surname)
TENIE SIMMONS 17. Father's Name (First, Middle, Last) SOLOMON ည FREEDMAN permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 HAMLET HILL ROAD, #1108 , BALTIMORE, MD 21210 EILEEN FREEDMAN/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HAR SINAI CEMETERY 12/26/2012 OWINGS MILLS, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ NEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PHAGI DEC ZOIZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) inding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 ☐ Yes 2 ☐ No ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Pother (Specify) ASS IS TED LIVING Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH CHARLES ST. BALTIMORE MARYL 6101 31. Date filed (Month, Day, Year)
TEC 2 7 2012 State 32. Registrar's Spnature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #9 17 18 £19b Per INF G944 10/07/2013 Ih

state of Maryland / Department of Health and Mental Hygiene

amend #1 £23b per PHY G944 10/28/2013 JH

Reg. No. 2 0 2 State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ /<u>1 8</u>/2012 8:50 AM Henry C. Filter Jr. Henry Charles Filter, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Centreville Hospice of Queen Anne's Queen Anne's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth **Funeral** (Month, Day, Year, 099-32-8650 Director NJ 1 X M 2 □ F 72 NY 02/28/1940 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Stevensville Queen Anne's MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21666 USA 230 Slipper Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ne eny injury or other traumatic event, the Medic 2006. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Insurance Agent 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Charles Filter Sr. Unk Mary Elizabeth Griffin ပ Henry C. Filter Sr. 19a. Informant's Name/Relationship (Type, Print) 19<u>2.M</u>jiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
—230 Slipper Lane Stevensville MD 21666 Henry C. Filter III Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/22/12 Glen Burnie MD Atlantic Crem 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 21. Signature of Juneral Service Licens homs 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ARKINSON Physician/ vears Medical resulting in death) Due to (or as a consequence of): Examiner 3 weeks Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): igned by the attending physician and be detached for use as the burlal-transit or Attending Physicien: The law requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 🔲 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 within 24 hours effer death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pag 2X No 1 🗆 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospice 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 romos eted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 7 2012 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore 2112 Poplar Grove St. 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8 Date of Birth 3502 Months Days Hours (Month, Day, Year) Director 1 X M 2 □ F 78 Vrs 12/28/1933 Georgia 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho Director MD N/ABaltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21216 2112 Poplar Grove St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Auto Repair Shop 8th Auto Mechanic Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) id Mental F marked o .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o မှ Oscar Griffin Laura Cosby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Griffin (Wife) 2112 Poplar Grove St. Baltimore, MD 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any Injury or ot 1 Burial 2X Cremation 3 Removal from State 23 Baltimore, MD On-Site Crematory 4 Doyation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. North and Ashress Hi Facili Brown, Jr. Funeral MD 21217 Baltimore, 2140 N. Fulton Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysiciani Esophingea rancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease of illijury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _ _ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2. autopsy performe 2 N ☐ Yes 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Hornicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death constrained at the time, date and place, and due to the cause(s) and manner as retak 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO057465 12/21/12 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRAGPAKSE MD 2835 5m.l Balt more MDZ/209 5703 Smith 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 04:04 PM Calvin R. Greene DELEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SINAT N/A HODPETAL OF BALTEMORE BALTEMURE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Hours UNK Director 1 🛛 M 2 🗆 F 78 Yrs 01/20/1934 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Importent: if Item 27 is marked other then "nature!", or iteme 23e or 28e-f eho any Injury or other treumetic event, the Medical Examiner must be notified at any Injury or other treumetic event, the Medical Examiner must be notified at any Disce. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 3823 Glengyle Ave. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ÚNK UNK UNK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Greene Bertha Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney Greene (Son) 2018 McHenry St. Baltimore, MD 21223 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burnal 2 St Cremation 3 Removal from State 26/12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD On-Site Crematory 21. Signature of Funeral Service Louise 22. June and Hadress of Farity Own, Jr. Funeral Home PA 2140 N. Fulton Ave. Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final - CNYESTEVE HEART FAILVEE Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of): Examine 7 DAYS PLEURAL EFFUSION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospitel or Attending Phyeician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ARTERY DIJEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC 24a. Was an KEDNEY DESEASE autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 2 ZN0 횬 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title-of certifle MD PAS 1825 DELEMBER 22,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELVEDERE AVE BALTEMES M SINAI HOSPETRE OF BATTMOUR 2401 31. Date filed (Month, Day, Year) State 2 7 Registrar

			Amend #25	Please, 27,28a-	Type or Pr	rint in	Black Ir	ndeli 8/1/ artme	ble Inl	k. Ensi lealth a	ure A and M	II Copie Iental Hy	s Ar	e Leg	ible.	1 1010	
		•	For State Registrar			,		Death		Reg. No. 2012 41040							
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	nd thow	٥٢	Usual Residence	of Decedent 10b. County			ty, Town or Lo	cation								10d. Inside City Limits	
	Aaryla 8a-fa Ilffed	Director	MD	Prince (George's	C1	inton									1 🛣 Yes 2 🗌 No	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17 Day Physician/ DEC Month GUION BERNICE ANN 2012 0:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Director 382-48-1389 1 □ M 2 🖾 F Sept. 10, 1945 67 MI r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 23 No Cheltenham Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10412 Farrar Ave. 20623 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 K Married ģ 1 X Yes 2 No. 5 If Yes, Give 1965 Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed **Black** Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs. Computer Analyst Datate1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည and 2 should be Nellie Kearschner Edward Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Leon Guion, Sr. - Husband Cheltenham, MD 20623 10412 Farrar Ave. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery : 1-4-2013 MD Cheltenham, MD 21. Signature of Funeral Service Licenses Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 ectarine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Hepatic Encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner End Stage Liver Disease Sequentially list conditions, if any hading transcription cause. Enter Underlying Cause (Disease or injury Dire to for as a consequence off-Exam or Attending Physician: The law requires that the death certificate be executed Cirrhosis for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hepatitis C Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Day Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute Kidney Injury Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Diabetes Mellitus Type II 24a. Was an 24b. Were autopsy findings available page 2 s has prior to completion of cause of death? this certificate Thrombocytopenia 2 No 1 ☐ Yes 2 ☐ No ☐ Yes director. 25. Was case referred to medica æ 26. Place of Death (Check only one) 10 Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury s after death.

I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie m. mehn 6/en Rd 0/10ex Spring, Mb 80910 . Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G935, 1/30/2013, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 25 Physician/ Grace Betty Jane 1040 December 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Anne Arundel Co. Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 219-30-2507 Director 1 □ M 2 🕅 F 03/31/1935 West Virginia 77 Usual Residence of Decede 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No MD Anne Arundel Co. Glen Burnie 5 10e. Street and 10g. Citizen of What Country? ^{Number} Cresthaven 23a Funeral United States 7025 Gresthaven Drive 21061 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ь þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan 1 ☐ Yes 2 X No Specify Specify. 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Direct Marketing 12 Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျ John Gaitanis Beatrice McElroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 7036 Cresthaven Drive Monica S. Grace / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State 12/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD Signature of Funeral 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DNO estiv disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Slace a Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed and -trai Due to (or as a consequence of): resulting in death) Last attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy yes 2 No certificate 2 No Yes 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. прletely the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) December 25 2012 D0073466 3 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital drive Glen Burnie MD DAGOBERT 31. Date filed (Month, Day, Year) State 7 2012 Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it at I wife at Expression and injury or other traumatic event, it at I wife at each and any injury or other traumatic event, it at I wife at each and any injury or other traumatic event, it at I wife at each and any injury or other traumatic event, it at I wife at each and a support of the any injury or other traumatic event, it at I wife at each and a support of the any injury or other traumatic event. Baltimore, Maryland 21215-0036

Funeral Director

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:35 A M Saul Robert Gershenson December 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year, Director 196-20-1115 1 X M 2 □ F Yrs 84 1928 Aug 17, Pennsylvania Usual Residence of Dece filed within 72 nous and tall Hygiene defected that "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Directo 1 Tes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3122 Gracefield Road #T02 20904 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 Korean 1 ☐ Yes 2 🖾 No Specify: 3 Divorced Specify: Completed Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 5+ Diplomat U.S. State Department other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked မ Joseph Gershenson Molly Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau / Wife 3122 Gracefield Rd. #T02 Silver Spring, MD 20904 Linda J. Gershenson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 12/26/2012 Woodbine, Maryland 21. Signature of Funeral Service Lieens 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD MO1251 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and I for use as the burial-transit Cause (Disease or injury Parkinson's Disease that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month ate has been signed by the a page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Diabetes Type II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown prior to completion of cause of death? Were autopsy findings available 24a. Was an Coronary Artery Disease autonsy this certificate Yes 2 No 1 Yes 2 No **Division of Vital** director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred I or Attending F after death. Certificate: (Month, Day, Year) 1 X Natural 5 Pending work?
1 Yes 2 No ne Hospital or Attendii n 24 hours after death. ne Funeral Director: A pletely filled in by the fo 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 only one) 29b. Signature and title of certified 29c. License number 044156 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) 3110 State

Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 530 Month 12 Physician/ Halina Gorski Day 22 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Good Sameritan Huspital Baltimore MO 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Poland 08/07/1913 216-32-6532 **Director** 99 1 M 2 F th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Maryland N/A Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5025 Crosswood Avenue 21214 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Floral Designer Horticulture Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jan Kozikowski Maria Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other tra Barbra Grela / Daughter 5025 Crosswood Avenue Baltimore, Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 12/29/2012 | Baltimore, Maryland 21. Signature of Juneral Service Lice Jee 22. Name and Address of Facility David J. Weber Funeral Homes PA any In 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician Conjective Heart Failure exacenhation disease or condition resulting in death) daus Medical Due to (or as a consequence of) Examiner days Phenomia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence oi): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the human. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CAD, SIP MI, SIP PACEMAKER 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2/ No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1\ Natural 5 \square Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD £55000 22-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

90134814

DHMH 17 Rev 06-2011

Khimberley D-Santiago, MD

31. Date filed (Month Day, Year)

State of Maryland / Department of Health and Mental Hygiene 41854 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Year IRA **GOLDMAN** De C IIAM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinau N/A Hosp. Baltimore BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03/11/1950 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Months Hours Director 215-50-0148 1 X M 2 - F 62 MD Usual Residence of Deceder I Hyglene. other then "neture!", or items 23e or 28e-f show vent, the Modical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Marylend Director MD BALTIMORE BALTIMORE 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 130 SLADE AVENUE. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ۾ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MERCHANT UNIFORM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mentel ပ္ WALLACE **GOLDMAN** RENEF ROSENFELD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SLADE AVENUE, #301, BALTIMORE, MD 21208 RENEE SMITH/MOTHER f Heelth or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 e
Depertment of H
Importent: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State SHAAREI ZION CEM. 12/24/2012 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS.. 21. Signature of Funeral Service License 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ Bram with Masses month disease or condition Medical resulting in death) Due to (or a consequence of): Examiner Pneumorua Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of) the Hospitei or Attending Physicien: The law requires that the death certificate be executed SIADH ettending physicien end for use es the buriel-trer Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 1 Yes 2 9 Unknown ete hes been signed by the page 2 should be deteched g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hepatitis 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available Substance prior to completion of cause of death?

1 Yes 2 No performed 2 N 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? (2) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending erei Director: A 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter or To the Funerei Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date and place are the time, date are the time, d 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) w AES-000 MBBS 2012 Dec 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital M BBS Sinai EDEM DINESH 31. Date filed (Month, Day, Year)

OFF. 2 7 2012 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Goldman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month Trum 4:58 P^M Dec. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore-Washington Medical Ctr Glen Burnie Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 176-26-6654 Director 1 🖾 M 2 🗆 F 76 Pennsylvania Dec. 23, 1935 sual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits tha Maryland Director 1 🗆 Yes 2 🗓 No Md. Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 230 fliad within 72 hours after death with 21122 USA 7918 Mansion House Crossing Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian. Armed Forces?
1 ☒ Yes 2 ☐ No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates. Korea White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Sunpaper Proofreader 0 Be permit. Page 1 and 2 should be fliad Department of Haaith and Mental H Importent: If item 27 is marked oth any injury or other treumetic even ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Edith Brubaker James Rayfield Gindhart, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 Lismore Ave. Glenside, Pennsylvania 19038 Joseph Gindhart (cousin) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Atlantic Cremation 12-26-2012 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, PA Kevin E Ecker 3204 Mountain Rd., Pasadena, Md. 21122 Moo175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MNG Medical resulting in death) Due to (or as a consequence of) Examiner ENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificata be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 1 Yes 2 g been signed by the s should be datached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation after deat Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours aft the Funerel Di mpletaly filled in Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print) Name and address of person who co

Registrar
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31. Date filed (Month, Day, Year)

32. Registrar's Signatur

808LAHDMARK DRIVE SHITE 128 GLENBURMIE MD 2106)

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ Alla U. Hogarth 755AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sausbury If Under 1 Year If Under 24 Hrs Hospice at the L NICOMICO Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 412-24-0245 89 Director 1 □ M 2 □XF Bristol, Tenn. Oct. 27, 1923 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico County Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1103 South Schumaker Drive 21804 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event, the Mental Factor. Armed Force Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 A No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 02 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Denton Myra Hopkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11839 Manor Road Glen Arm, Maryland Mr. Victor Kent Underwood /son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Baltimore County Date cemetery, crematory or other place).
Dulancy Valley Manorial.
Carcars 1 X Burial 2 Cremation 3 Removal from State Wednesday 4 ☐ Donation 5 ☐ Other (Specify) Dec.26,2012 Timonium, Maryland 21. Signature of Funeral Service Licensee Jeffrey L.Gair, Sr. CFS 22 Name and Address of Facility Licensee Funeral and Cremation Center, P.A.

Lic. #M00677 2325 York Road Timonium, Maryland 21093–2215 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ligar failure. List only one cause on each line. Immediate Cause (Final Onset and Death stal Heart Failu Physician/ disease or condition resulting in death) Medical Due to for as a consequence off: Examiner Howlin Stroses Sequentially list conditions, if any, hading to in mediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 14 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 Yes No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 063199 12/22/12. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).
YOGESH VOHILA 910 ENSTELM SHOLE SAUSBURY MD 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Morningside House of Ellicott City Ellicott City Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 443-30-1166 1 XM 2 🗆 F 87 July 2,1925 Usual Residence of Decedent Oklahoma 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene.
I them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City. Town or Location 10d. Inside City Limits Director Maryland Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10001 WindStream Drive 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: white 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Minister Methodist Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Andrew Howard Elsie Vivian Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bessie Howard/wife 10001 WindStream Drive Columbia, Maryland 21044 permit. Page 1 and Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/24/2012 Baltimore, Maryland ture of Funeral Service 22. Name and Address of Facility Cremation Society of Maryland, Inc Stephanie Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani ardio throng stic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Theosdeonic Cardiovasimilat Sequentially list conditions, if any leading to inchediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and Id be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been si funeral director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director. 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assured Living 2 🕅 ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred facility 1 Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 24 hours after deatl Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unie, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) mule D47683 12/23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller Po 1525 OWINGS Mills MD 2111 31. Date filed (Month, Day, Year)
DEC 2 7 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Donald Harrison 9:55a December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10129 Frederick Road Ellicott City County Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 219-32-7889 1 X M 2 - F 75 Maryland Jan. 11, 1937 23a or 28e-f ehov of and 2 should be filed within 72 hours after death with the Maryland of Health end Mentel Hyglene. If them 27 is marked other then "netural", or items 23a or 28e-fehor other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 ☐ Yes 2 🗓 No Maryland Howard <u>Ellicott City</u> 10e. Street and Numbe 10g. Citizen of What Country? 10129 Frederick Road 21042 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 1963 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 1963 Specify: white 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Bianedical Engineer Supervisor D.C. General Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carl Harrison Rita Russo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Marie Harrison/wife 10129 Frederick Road Ellicott City, Maryland 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of H
Important: If ite
eny injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 12/24/12 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Squamous Cell Carcinoma of disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Emphysema 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 M No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The defice of Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30573 MD. December 24, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21044 Jon K. Minford, M.D. 10710 Charter Dr., Suite GO20 Columbia, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec. 2012 Ethel Mae Hunt 12:30P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Fairhaven Health Care Center Sykesville Carrol1 . Social Security Number 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Mar 10, 1 Months 355-12-2284 Hours Country) **Director** 1 🗆 M 2 🗶 F 85 ILUsual Residence of Deced 28a-f show within 72 hours after death with the Maryland at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified MD Carro11 1 Tes 2 X No Sykesville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 7200 Third Avenue 21784 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 TNo Specify: Completed 3 Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Maction 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Flight Attendant Airline Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Patrick Fenwick Brown Muriel Drew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Forrest J. Hunt (Son) 1710 New Hampton Lane, Woodstock, MD 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington Natl Cem. 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses 400764 Buan PO Box 195 Sykesville, MD 21784 HU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line End Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate
File Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-trai that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death g Unknown q 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autops performed 1 Yes 2 No 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at after death.

Director: After t 28d. Describe how injury occurred 5 Pending Natural injury 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature D34849

DHMH 17 Rev 06-2011

State Registrar Elderson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1645

illiam lan

31. Date filed (Morth, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle 2. Date of Death Physician/ tarris Medical Examiner street and number Baltimore owson Hospice If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) Director 1 XM 2 □ F Yrs. CLM 2 should be filed within 72 hours after deeth with the Maryland th end Mentel Hyglene. 27 is marked other then "neture!", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore ssex 1 ☐ Yes 2 ☑ No 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 USA Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life BO NOT use retired) ondary (0-12) College (1-4 or 5+) ransportation ruck 8 Father's Name (First, Middle, Last) ၉ Harris Route Number, City or Town, State, Zip Code) Injury or other 20b. Place of Disposition (N permit. Page 1 a Department of H cemetery, cre 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the d shock, or heart fai sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Immediate Cause (Final STAGE VER Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attanding Physician: The lew requires that the death certificate be executed within 24 hours effer deeth. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Tes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: ၉ 1 🗌 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

Maryland 21215-0036

Baltimore.

Box 68760

P.O.

Records,

Division of Vital

6701 N Charles 31. Date filed (Month, Day, Year) 62. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

D72139

Street Suite 4105 Baltimore MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8, per fh, g934 12-27-12 sm
State of Maryland Department of Health and Mental Hygiene
amend #7, per fh, g935 1-2-13 sm For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 21, 2012 Physician/ Chester W. Harvey 9:14 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2810 Benson Rd. Carrol1 Finksburg Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth July 10, 1947 Pennsylvania XXM 2 D F -65-66 Yrs. Director 185-36-9385 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carrol1 Finksburg 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2810 Benson Rd. 21048 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by ☐ Yes **X** X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: ₩Widowed 4 Divorced White Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Bank Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. Chester W. Harvey F1orence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Chester W. Harvey / Son 1603 JUbilation Ct. Herndon, VA. 20170 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Der artment of H Important: If ite any injury or ot 1XXBurial 2 🗆 Cyennation 3 🗆 Removal from State Evergreen Memorial 4 Donation 5 Other (Specify) 12/27/12 Finksburg, MD 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Hnten Disease Immediate Cause (Final oronary Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Dust to (or as a consequence of): if any leading to harmed cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Disond Records, 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to predical Division of Vital To Be 26. Place of Death (Check only one) Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 D Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) estminster MD chet 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nald Kevin Ha			it of Health and Mental H e of Death	ygiene Reg. No. 20	2 4186
Physicia edical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year December 17, 2012	3. Time of Death 1710 hrs
		4a. Facility Name (if not institution, give street and number) Franklin Square Hospital	4b. City, Town, or Location of Death Rosedale	4c. County of Deat Baltimore Co	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 212–23–6503 1XXM 2 F 24	yrs. If Under 1 Year If Under 24Hrs Months Days Hours Min		rthplace (State or Foreig ountry) Maryland
d how any	_	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or I Maryland Baltimore Perry I			10d. Inside City Limits
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygrene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 725 Cross Road 9725 Cross Road	10f. Zip Code 21128	10g. Citizen of What Cou	707
er death with , or items 2.	Funeral	11. Marital Status 1 XXNever Married 2 Married Armed Forces? 1 Yes 2 XX No 3 Widowed 4 Divorced If Yes, Give Year	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 Yes 2/Y No specify:	Rican, etc.) White, etc.	rican Indian, Black,
5 72 hours aft in "natural" al Examine	ompleted by	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	1 Yes 2XX No specify: cedent's Usual Occupation (Give kind of- ing most of working life. DO NOT use ret		White /Industry
15-0036 filed within 72 Il Hygiene. ed other than 't, the Medical	ပ	11 17. Father's Name (First, Middle, Last)		Cemetery (First, Middle, Maiden Surname)	
e, MD 2121 1 and 2 should be fill Health and Mental I item 27 is marked r traumatic event,	To Be		Janet Mailing Address (Street and Number or Cross Road Perry Hall,	Helen Butt Rural Route Number, City or Town, Stat Maryland 21128	e, Zip Code)
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	ĺ	20a. Method of Disposition 1 WBurial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition or crematory Dulaney	isposition (Name of cemetery, or other place) Valley Mem Grdns 12/2	Date 20c. Location - City o	ryland
Balt permit. Depart Impor injury		21. Signature of Funeral S. Arige Licensee 23. Part I. Enter the disease/or complications that caused the death. Do not en	6500 York Road Baltim		Home Inc
Physician /Medical Examiner		Faith. Enter the disease or conjunctarions in the caused the death. Build enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Narcotic Intoxicat Due to (or as a consequence of):		or respiratory arrest, Shock, or fleart	Between Onset an Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
be executed be ician and urial - transit	Exa	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	nor mo c025 1 2 1	2	
Ox 6876(ath certificate attending physor use as the b	siciar	X UNPENDED AMENDED 23a, 27, 28a-f 106, 19b per fh IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown AMENDED 23a, 27, 28a-f 106, 19b per fh 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 5	Petal death 3 Ectopic pregn. Other (Specify)	23d. Date of deliver	ry Day Year
i, P.O. Bires that the designed by the	d by Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to	
Records, The law require ficate has been si page 2 should be	Completed				utopsy findings availab completion of cause of es 2 No
of Vital Rec g Physician: The ter this certificate eral director, page	To Be C	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpa 27. Manner of Death 28a. Date of Injury 26b. Tim		only one) ng Home 5 Residence 6 Othe 28d. Describe how injury occurred	er:
Division of Vital tal or Attending Physician is after death. al Director: After this certical in by the funeral director	ertification:	1 Natural 5 Pending Investigation Pending Investigation Representation Pending Investigation P	1 Yes 2 X No	unknown 28f Location (Street and Number or R	ural <u>R</u> oute Number, Cit
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ပ	4 Homicide determined (Specify) Group Hom- 29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death	e occurred at the time, date and place, and	or Town, State) 1022 N. M. Essex, MD. didue to the cause(s) and manner as sta	ted.
To the Ho within 24 h To the Fu completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or inveand manner stated. 29b. Signature and title of certifier	stigation, in my opinion, death occurred 29c. License number O.C.M.E.	at the time, date and place, and due to t 29d. Date signed (M. December 20, 2	onth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900		<u> </u>	
St Regist		31. Date filed (Month, Day Year) 7 2012 32. Registrar's Signature	barre	24	
MH 17 Rev 1/2		ORIG	INAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:05 P_M Physician/ Edwards Harrover Robert 2²7 201² Medical 4a. Facility Name (if not institution, give street and number) o. City, Town, or Location of Death Havre de Grace 4c. County of Death Examiner Harford Memorial Hospital Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 7. Age (In yrs. last birthday) Days 1 X M 2 □ F 162-20-9600 Hours 84 9 M67 1328 Pennsylvania Director Usual Residence of Decedent per rit. Page 1 and 2 should Le filed within 72 hours after death with the Maryland Der artment of Health and Mental Hygiene. Der artment of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Havre de Grace Maryland Harford 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 2 1 0 7 8 Funeral 916 Woodhaven Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛛 No Specify: If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Manufacturing College (1-4 or 5+) Elementary/Seconday (0-12) Metallurgical Engineer 12 Be Maryland 18. Mother's Name *(First, Middle, Maiden Surname)* Virgie Ellen Long 17. Father's Name (First, Middle, Last) မ Robert E. Harrover, Sr. 19a. Informant's Name/Relationship (Type, Print)

Shirley Z. Harrover / Wife | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 Woodhaven Crt., Havre de Grace, MD 21078 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State Harford Mem Gdns. 12/28/2012 Aberdeen 4 Donation 5 Other (Specify) 21. Signature J Fun ral Service 2 Tarring-Cargo Funeral Home, P.A. Aberdeen, MD 21001 Dones 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DUODENAL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** SEVERE GASTROINTESTINAL BLEEDING sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner SHOCK YPONOLEMIC law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): resulting in death) Last IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ tor: After this certificate has been signed by the atter the funeral director, page 2 should be detached for u in the past 12 months? Month Dav Year ☐ Yes 2☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be (26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred I or Attending P s after death. I Director; After t work? 1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aft To the Funeral Dir Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0069118 12-24-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khalid icthawala 601 Kevolution St. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State		State of M	arylan		artment <i>tificate</i>			and M	lental Hy		00	_		0.05
		Registrar 1. Decedent's Name	e (First, Middle, La	ast)		Cei	incate	OID	Calli		2. Date of D	Reg. Neath	No:2	2	3. Time	of Death
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To vit		29b. Signature and title of continer	Wiene	(3RN	P	29c. License	number 5	2		29d. Da	te signed	(Mgnth, D	ay, Year)
21		 Name and address of person w Michael Warren 					rint) inton, MC	2073	35					
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σ. Records, Division or Vital Hospital or Attending

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of cortifie

30. Name and

ATTENDING M.D deress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00073354

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2013 Loriene December Medical Sharon 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstownn If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Director 213-46-3082 1 D M 2 K F 66 Maryland 1946 Jun. 25, Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1

Yes 2 No Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U.S.A. 55 E. Washington St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc ò 1 Never Married 2 Married ۵ 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify. Specify: "naturel", Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) own home 12 homemaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Importent: If item 27 is marked other eny injury or other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oliver Jacob Weddle Mary Horner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keymar, MD 21757 12906 Woodsboro Pike Dwayne E. Weddle/ brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Bunal 2 🔀 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) County Cremation 12/26/2012 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home, P.A. affarin New Windsor, MD 21776 P.O. Box 249 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onserand Death Immediate Cause (Final Physician/ Ovonavy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine death certificate be executed espirator ettending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۶ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 🔽 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun Hospital or Attending 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12-22-12 028363 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANZAR J. SHAR 368 nell Nagetern 190 21740 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Maryland 21215-0036

Baltimore.

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 12 Sheryl L. Johnson 2012 6:50 pM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8 Date of Birth Days (Month, Day, Year) Hours 215-64-7627 1 □ M 2X F 57 03/14/1955 MD 10d. Inside City Limits 10c. City, Town or Location 10b. County Baltimore N/A 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 2845 Lake Ave. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Public College (1-4 or 5+) Elementary/Secondary (0-12) Balto. City Schools Executive Secretary 6+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Johnson Beatrice Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2845 Lake Ave. Baltimore, MD 21213 Johnny Johnson (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cernetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) On-Site Crematory 10 Baltimore, MD ²² Novembresh Facilitrown, Jr. Funeral Home PA 2140 N. Fulton Ave. Baltimore, MD 21217 21. Signature of Funeral Service Lice 22. Name and Address H Facility Own, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final 100 disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of):

Physician/ Medical Examiner Exami attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed

ate has been signed by the a page 2 should be detached

After this certificate has

To the Hospitel or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director,

Physician/Medical

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Certificate:

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Director

permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records, P.O.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death

9 Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Year Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed Yes 2

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No

25. Was case referred to medical 2 (20No 1 Tes

Manner of th

Accident

1 Natural

(Check

Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 28c. Injury at 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

26. Place of Death (Check only one)

1 🗌 Yes

3 Suicide 4 Homicide 6 Could not be determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signa and title of certifier

5 Pending

Investigation

29d. Date signed (Month, Day, Year) 206

10/

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W

Registrar

State Registrar

within 2 To the I

only one 9b. Signature

31. Date filed (Month, Day, Year)

DEC 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

aheen

7 2012

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day rbara 20,2012 Medical December Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 10WSO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 216-24-7761 1 🗆 M 2 🔀 F 83 Yrs May 5,1929 Maryland Usual Residence of Decedent or items 23e or 28e-1 shov permit. Pege 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Heelth end Mentel Hyglene. Importent: If Item 27 is merked other then "neturel", or Items 23e or 28e-1 shown in Jury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 25 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 9 Lombardy Place 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ٥ 1 Never Married 2 Married ltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: white Completed 3 ☐ Widowed 4 🖾 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Campbell Soup Executive Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Louis P. Walker Elizabeth McComas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lindsay Mangan-daughter 3010 Second Avenue-Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Carcemation 3 Removal from State Evans Funeral Charel Dec. 24, 2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) and Cremetion Ser Pelair 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services
Evans Funeral Chapel and Cremation Services 21. Signature of Funeral Service Licensee e L. ME Fude 8800 Harford Road-Parkville Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Digsetes Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown After this certificete hes been si funerel director, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 🛭 To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28d. Describe how injury occurred 1 Accident To the Hospital or Attending within 24 hours after deeth.
To the Funerel Director: Afte completely filled in by the fun 5 Pending Division Investigation 3 D Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37016 MD December 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lenneth M. Greene, MD 6701 N Charles St., Su. te 4104 Baltimore, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, 6935, 1/3/2013, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death M12/21/2012 Physician/ Mary Ann Jackson 10:40 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomary General Hospital 01ney If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 88 Pennsylvania Feb. $\frac{17}{18}$, 1924 206-12-0033 1 🗆 M 2 🗶 F Yrs. Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours efter death with the Maryland 10a. State 10c. City, Town or Location in then "netural", or itams 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗌 Yes 2 🗆 No m CARREI WOODBINE 10e. Street and Number 10g, Citizen of What Country? 21797 ISA 7409 MORGAN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Paga 1 and 2 should be filed within 7. Department of Haalth and Mantel Hygiene. Importent: if item 27 is merked other then any injury or other traumetin. College (1-4 or 5+) Elementary/Secondary (0-12) Postal Worker USPS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN ARLINGTON SOPITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAU 64 Tin EVENIN CHARKSVILLE TACKSA Rn 5540 TEN OAKS 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metro Crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/22/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Fund Service Gensee Stephnaie Custer 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 21. Sign tur 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAY Physician ASPIRATION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PARKINSON'S Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Hospital or Attending Physician: The law requires that tha death cartificate be axecuted signed by tha ettanding physicien and d be dateched for usa es the burlal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☒No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FBRIUM? ATRUAL icata has been sig r, page 2 should b 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy cartificata has performed' 1 Yes 2 7No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this cartific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 21,2014 125947 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mp JAUGOV, MD TEN OAKS ROAD CLARICSVILLE 21029 5540 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	death r items iner m		11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	J.S. 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
5-0036	e filed within 72 hours after death with the Maryland trail Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No			Specify: 3	
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	1 and 2 s if Health s item 27 i other tra		Kandall Baco	te Jr.	942 Exeter	. / ./	Avenue.	<u> </u>	ore, MD21218
Baltimore,	o ° ± ±		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposition (Name of cemetery, crematory or other pla	<i>/</i> :	Date	20c. Location - City o	
altin	ギモセラ		4 Donation 5 Other (Special 21. Signature of Funeral Service Licens		remation (en) 22. Name and Addre	ess of Facility	7-2012	Hanover Breene Fu	teral Services
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Box 68760	death certificate be ne attending physici ed for use as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of d	lelivery
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tal	sician: The certificate irector, paç	Be C	25. Was case referred to medical examiner?		26. F	lace of Death (Chec		2 (2 √No) 1 □ Y	es 2 No
ž Š	Physic rthis o	잍	1X Yes 2 5 No 27. Manner o⊁Death	Hospital: 1 Inpatient 2 28a. Date of injury	ER/Outpatient 3 DOA Oth 28b. Time of 28c. Injur			dence 6 Other (Spe	ecify)
o uo	ending ath. rr: After he fune	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury wor		28d. Describe r	now injury occurred	
Division of Vital Records,		Certificate:	3 Suicide 6 Could not b 4 Homicide determined		nome, farm, street, factory, office fy)		28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
_	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check 2 L Medical Exami	iner: On the basis of examinatio	wledge, death occurred at the tim on and/or investigation, in my opini	on, death occurred a	at the time, date a	and place, and due to the	e cause(s) and manner stated.
	To the within 2 to the comple	ğ	only one) 3 Certifying Nurs 29b. Signature and title of certifier	se Practitioner: To the best of	my knowledge, death occurred at	the time, date and p	lace, and due to t	the cause(s) and manner	as stated.
	(3)				M.D RE	ES-00	00	December	-09,2012
			30. Name and address of person who c	MAR	n 23a) (Type, Print)	ans s	+ . Ra 1	Amore 1	MD. 21287
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa	·	J		110100	
	Registra	ır	DEC 2.7	2010 Margard	. S. Sololo				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 0300 Russell Jack Jones . Medical Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death more 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec 16, 1947 **Funeral** 7. Age (In yrs. last birthday, If Under 24 Hrs 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Hours New Jersey Director 65 113-36-4325 Usual Residence of Decedent and whitel Hygiene.
I is marked other than "natural", or items 23a or 28a-f show marked other than "deficial Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 🗌 Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21244 USA 1 Guild Hall Ct. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 🙀 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) internet technician Comcast Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Amelia Bristol Hules Jones 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $86\ Barry\ Dr;\ Westbury,\ NY\ 11590$ Audrey Porter - sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Sign re funeral dicedice re Les Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ mona Medical Examiner hours the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Philishin of What Hecords, P.O. Box 68760

edical Examine	franchise to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Lolon Cancer Due to (or as a consequence of):	`			Months
nysician/in	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
red by P	Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.			the cause of death?
adilloo				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
מַ	25. Was case referred to medical examiner?	,	26. Place of Death (Che	ck only one)		,
2	1 Yes 2 No	lospital: 1 Inpatient 2 ER/Outpatier	ot 3 DOA Other: 4 Nursing H	lome 5 Residence	6 ☐ Other (Spec	ify)
care:	27, Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
II Vei	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Stat		ral Route Number,
Medic	(Check 2 Medical Examine	cian: To the best of my knowledge, death over: On the basis of examination and/or invested Practioner: To the best of my knowledge, or	igation, in my opinion, death occurred	at the time, date and place	e, and due to the	cause(s) and manner stated.
	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month	Day Year)

Baltimore

State Registrar 1

completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 JORDAN GLENN EUGENE JR. 3:20 p Dec. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care Wheaton Wheaton Montgomery If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 190-40-4255 1 M M 2 □ F Yrs 65 9/27/1947 PA 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f sho any injury or other traumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 X No MD Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 1410 Filmore Rd USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. ۵ 1 Never Married 2 Married ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates 3 Divorced Specify. Completed **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Manager Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Betty Jane Robinson Glenn Eugene Jordan, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Starlene Jordan - wife 1410 Filmore Rd. Fort Washington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metropolitan Crematory 12-22-2012 Alexandria, VA Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Physician Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 3 mos Decubitus Wounds Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of attending physician and I for use as the burial-transil Cause (Disease or injury The law requires that the death certificate be executed Diabetes Mellitus that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day 5 Other (specify) ipital or Attending Physicien: The law requires that the dea ours after death. eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached if 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Chronic Kidney Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy 2 No 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work: 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the Hosp within 24 hor To the Funer completely fi (Check

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OL.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0033813

29d. Date signed (Month. Day, Year)

Division o	f Vital	Records,	Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be execumithin 24 hours after death.	hysician:	The law requires the	hat the death certificate be execu

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		Decedent's Name (First, Mich.)	idie, Las	it)					2. Date of D	eath	201	_	3. Time	e of Death
Physicia /Medic		Shirl	ey L	ee Kermi	sch				Dec.	19, 2	012	ear	9:	30 P M
Examin	er	4a. Facility Name (If not instituted 8125 Hickory				C		or Location of Deat		4c.	County of Howa			
Funeral	1	5. Social Security Number	6. Se	ex 7.7		last birthday) If Under 1 Yea	ar If Under 24 Hrs	-	irth		. Birthp	lace (Sta	ate or Foreign
Director	ļ	219-30-9548	1	□ M 24□XF	78	8 Yrs.	Months Day	s Hours Min.	8. Date of Bi (Month, D 06-03	-1934	+	Cour	M M	ID
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filed within 72 hours after death with the Maryland Hygiene. Hygiene, wither than "natural", or items 23a or 28a-f show ant, the Medical Examination must be notified.	Director	MD	Howa	rd			E11	icott Cit	у				1 \(\)	Yes 2 □ No
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in 72 in "nat	Completed	15. Deced (Specify only hig	hest gra	de completed)	-5.)	16a. Deci	edent's Usual Oci e kind of work doi DO NOT use ret	cupation ne during most of woi ired)	rking	160. K	ind of Busi	ness/in	lustry	
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be file tal Hy d oth event	Be	17. Father's Name (First, Midd	. ,					18. Mother's Nar						
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ind 2 satth all		Howard Kermis				8125		y High Co						
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan In-partment of Health and Mental Hygiene. In partment of Health and Mental Hygiene. In partment: I firm 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination must be notified a once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio	n 3□	Removal from Sta	20b. l	Place of Disp cemetery, cre	osition (Name of ematory or other p	olace)	Date	20c. Lo	ocation - Ci	ity or To	wn, State)
t. Pag rtment rtant:		4 Donation 5 Dther	(Specify	Entombme			-	Park 12-				-		
D par Impo any l		21. Signature of Funeral Savi	ce lice:	See Zul	V2	. ,		dress of Facility Ga , 7250 Wa	•					
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/Medical Examiner		resulting in death)		Due to (or	as a consec	quence of):		V						71009
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		bDue to (or a	as a consec	quence of):								
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or with	2	29b. Signature and title of cert	fier	10 K	A Car	LA	29c. Lici	ense number	1	t-man-	ite signed		-	7012
m		30. Name and address of pers	on who	completed cause of	f death (Ite	m 23a) (Tvpe	, Print)	2000		176	und	JK!		1 10
10		Nicholas W. Ko	outr	elakos. N	MD. 10	0710 C	harter D	r., GO20,	Columb:	ia, M	ID 210)44		
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negistr	al	שבט מ	• 40	- Janu		- 19º								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Pauline Pearl Keys :25p Medical December 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing Center- Mt. Airy Mt. Airy Carrol1 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country) Russia (Month, Day, Year) Aug 12 1912 100 Director 220-34-7097 1 □ M 2 🖔 F ed other then "naturel", or Items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Importants if fiem 27 is marked other than "nature!" ~ " other traumatic event and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "nature and "na 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Mt. Airy 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21771 3111 Glen Abbey Drive 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ white 1 ☐ Yes 2X☐ No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) grocery store clerk grocery 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Ida Scheriffman ဥ Nathan Berman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3111 Glen Abbey Dr., Mt. Airy, MD 21771 Joyce Vecchiarelli (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Randallstown, MD Beth El Memorial 12-24-12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Jang. eduate typispe. P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cerebrova o cular Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this continuation has been approximated to the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the continuation of the con ettending physician end I for use as the burial-transi Cause (Disease or injury that initiated eve resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year ate has been signed by the e page 2 should be detached i 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No completely filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗖 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) unsusiya, MD 51705

Registrar HMH 17 Rev 06-2011

State

Malcolm

DR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIYA 349 Malcol

31. Date filed (Month, Day, Year)

349

12-21-12

Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Lawrence Edward Kridenoff 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rosedale FRANKLIN Square Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Min. March, Dev. Year) 925 87 Director 219-16-9398 1 ☒ M 2 ☐ F Yrs Usual Residence of Decede or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified et 10a. State 10c. City, Town or Location Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21237 1225 Rustic Avenue しなら このかり 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗆 No 1942 permit. Page 1 and 2 should be filed within 72 hours after of Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or i eny injury or other traumatic event, the Medical Examin Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 Divorced 1945 Specify: Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) metal worker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lillian Hammerbacher Jesse Charles Kridenoff denof 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1225 Rustic Avenue; Baltimore, MD 21237 Doris R. Kridenoff - wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lience, Ronald S. Ware, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ nearT failure Cong ESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner A Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami ng physician and as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ò in the past 12 months? Month detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? ۾ Records, The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has I completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2 autopsy Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗷 No |<u>유</u> 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

11 16 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Mary land

white

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year,

Balto md 21237

State Registrar

mallalien 4000 FRANKLIN SQUARE OR 3. Registrar's Signat arka

Medical

29a. Certifier

only one) 29b. Signature and title of certi

2 | 3 |

Rachel Leah

DEC 2 7 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41879 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Klass Mark December 2012 10:42 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2821 Onyx Road Parkville Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 213-76-2740 Director 54 1**X** M 2 □ F 04-22-1958 Maryland Usual Residence of Deceder 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene.
Item 27 is marked other then "naturel", or Items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Maryland Baltimore 1 Yes 2x XNo Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2821 Onyx Road 21234 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. þ Black, White, etc. 1 Never Married 2 x Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxx No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD Hotel Supply Butcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Joseph Goerge Klass</u> <u>Patricia Hipslev</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Brenda Klass - Wife 2821 Onyx Road Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Importent: If It
any Injury or o Date 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 12-26-2012 Towson, Maryland 21. Signature of Funeral Service Livens 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition 6 Medical resulting in death) Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending filled in by the Accident Investigation 12012 1042AM 1 🗌 Yes **Director:** 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Tural Rolle Number, City or Town, State) 2821 CVXX CCC determined 24 hours a 10mp Parkville Maryland Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date, and due to the cause(t) and manner as stated. 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21.2012 30. Name and address of person who completed cause of death (Item; 23a) (Type, Print) Trimb 31. Date filed (Month, Day, Year) 22. Registrar's Signature 17 Registrar

		-	State of Marylan				•		•	
		For State Registrar			ificate of De		vicinal Fig	Reg. No	ZUIZ	41880
Physicia Medic		1. Decedent's Name (First, Middle, Last Wanda Fay Kelly)				2. Date of De Month	eath Da	Year O	3. Time of Death 3: 35 PM
Examir		4a. Facility Name (if not institution, give s	street and number)		4b. City, Town, or Lo	ocation of Death	1 3	4c	. County of Dea	
		Franklin Squar 5. Social Security Number 6. Se	e Hospita	(Rosea	lale			Baltir	
Funeral		1 220- 50-2151 I	(1		If Under 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Bi	rth	9. Bir	thplace (State or Foreign
Director		Usual Residence of Decedent	□M 2 🖾 F 64	Yrs.			April 7	7, 19	948 Ma	aryland
and show	5	10a State 10b County	10c. Cit	y, Town or Loca						10d. Inside City Limits
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a or 2	Ö	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Co	ountry?
h with	Funeral	18 Brookfarm Cou	ct Unit A		21128				USA	
riten Iner		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. W	as Decedent of Hispa res, specify Cuban, I	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
s after	d by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ሺЖlo If Yes, Give Year or Dates.	11	∐Yes 2∐KNo :	Specify:				hite
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Insperment of Health and Mental Hygiene. Insperment of Health and Mental Hygiene. Insperment of Health and Mental Hygiene was any Injury or other traumatic event, the Medical Examiner must be notified at once.	ם	17. Father's Name (First, Middle, Last) Levi Harrell			18	8. Mother's Nam Hilda H		, Maiden	Surname)	
hould and M s mai		19a. Informant's Name/Relationship (<i>Typ</i> John Kelly II/Sot	pe, Print)	19b. Mailing	Address (Street and	Number or Rura	al Route Numbe	er. City or	Town, State, Zi	p Code)
nd 2 s ealth a n 27 i		John Kelly II/Son	1	48 Bi:	rch Street	t Lowel	1, MA	0185	52	
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t. Pag tment rtant:		4 Donation 5 Other (Specify)	Par	kwood	Cemetery	12/2	4/12	Balt	imore N	4D
permi Depar Impol any Ir		21. Signature of Funeral Service License	70.		Name and Address of				MD 210	21.6
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certif	2	23b. Was decedent pregnant 2	3c. If yes, outcome of pregnal		- versus as as Vici				23d. Date of de	livery
death ne atte ed for	sicie	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐							23d. Date of delivery Month Day Year	
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es the	<u>\$</u>	Part II. Other significant conditions cor		uiting in the und	ieriying cause given	in Part I.				the cause of death?
requir	ete		ation,							robably 4 Unknown
has the	립	Chronic obst	ractive Pul	monar	y Disea	se	24a. Was auto		24b. Were au prior to death?	topsy findings available completion of cause of
n: The ficate or, pa	ပ္တို	25. Was case referred to medical					1 🗆 Yes			2 🗆 No
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g Phy erthis	e.	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	28c. Injury at	4 Nursing Ho	me 5 LJ Resi 28d. Describe l			ify)
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oltal o								,		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 ⊔ Medical Examina	cian: To the best of my knowled er: On the basis of examination Practitioner: To the best of m	and/or investig	ation, in my opinion, o	leath occurred at	the time date a	and place	and due to the	cause(e) and manner stated
To th To th		29b. Signature and title of certifier		, managa, a	29c. License nu		cc, and dde to		e signed (Month	
		Josha D	well.		ROSO	200		12-	20 20	213
10 thr		30. Name and address of person who co			nt)			- : 3		- 3
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 1 1840 Kenneth Ellis Kinnamon 2012 Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Olneu Medstar Montgomery Medical Center 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days 445-32-7729 1 X M 2 □ F Texas May 28, 1934 Director 78 ual Residence of Deceder 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Market Framiner must be notified at traumatic event, the Market Framiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No Rockville Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 20855 Funeral 17412 Beauvoir Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1959— Black, White, etc. 1 Never Married 2 Married <u>ک</u> White 1 ☐ Yes 2 🛣 No Specify: Maryland 21215-0036 Specify. 3 Widowed 4 Divorced 1980 Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Je filed wn. -tal Hygiene. (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Medical School Professor 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) Mary Levona McGill 2 Ellis Kinnamon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17412 Beauvoir Blvd., Rockville, Maryland 20855 1 and 2 s if Health a item 27 l Arlene E. Kinnamon - Spouse 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Dunial 2 Dunial 2 Dunial 2 Removal from State Lincoln Crematory: 01/02/2013 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Disat Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequ Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a conseque Physician/Medical Box 68760 attending I as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death q Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 Yes ျ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27 Manner of Death Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature appd title of certifier RINIVASA 74816 22 2012 NARHYANASWAMYM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Dr., Olney, MD 20832 1ANASWAM9 NARA MI SRINIVASA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

/DHMH 17 Rev 06-2011

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1605 Paraskive P. Kalamoutsos December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 216-80-4607 1 □ M 2 🕱 F April 13,1916 Greece 28a-f shov build be filed within 72 hours after death with the Maryland of Mental Hygiene.
marked other than "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at **Funeral Director** Maryland Montgomery Laytonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19908 Belle Chase Drive 20882 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Lore, Mary,
Lorenti. Page 1 and 2 should be be be partment of Health and Mimportant. If item 27 any injury or contract. Athanasios Mantzouranis Eleni Pichios 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2109 Coleridge Dr., Silver Spring, Maryland 20910 Irene Chapin - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/29/2012 | Silver Spring, MD 4 Donation 5 Other (Specify) Gate of Heaven Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Marina 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Physician/ Advanced Dementia Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or Injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed be detached for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by , 24 hours after death. • Funeral Director: After this certificate has been siç letely filled in by the funeral director, page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} မ 1 ☐ Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural 5 Dending Accident 1 Tes 2 🗀 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or inventioning in the control of the cause (s) and manner as stated. 29a. Certifier within 24 how To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of mylknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) December 25, 2012 D45471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1111 Spring Street, Suite 214, Silver Spring, MD 20910 M.D., Yeheyis Negussie,

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

З€. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:45 A. M Melva Karn December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4400 Washington Blvd. Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 212 42 0198 Director 1 🗆 M 2 🖾 F 68 Maryland 08/08/1944 fshow 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 4400 Washington Blvd. 21227 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Line Worker Glass Company 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ UKIKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4400 Washington Blvd. Samuel Karn / Husband Baltimore, Maryland 21227 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o 1 Burial 2 KCremation 3 Removal from State 12/24/2012 Bayview Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Between Immediate Cause (Final disease or condition resulting in death) MYOU Onset and Death INFAICTTON Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗆 No Yes 2 Z 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALC NON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G935, 1/2/2013, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kaut Merc Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2 Forge Hill Road Perry Hall Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/30/1939 9. Birthplace (State or Foreign Days Country) Maryland Director 1 □ M 2 🖔 F 219-34-1404 73 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "neturel", or items 23s or 28s-f eho 27 is marked other than "neturel", or items 23a or 28a-f sho traumatic event, the Medical Examiner is ust be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD **Baltimore** Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Forge Hill Road 21128 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Solomon Mildred Louise Nalls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronny Wenger / Daughter 2 Forge Hill Road, Perry Hall, MD 21128 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any Injury or o 1 ☐ Burial 2 🔯 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/23/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician Onset and Death LUNG disease or condition Can cer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physicien and ched for use es the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerial Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the bunal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier MSRajapanlmo 29c. License number 29d. Date signed (Month, Day, Year) D0057465 12/21/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultmore MD 21209 5203 NS (Cajapa Ksem) 2835 SmM N 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2 7 2012 Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 22, 2012 Physician/ Kim Kyong Kwon Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Boyds 12719 Fernberry Lane 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth If Under 1 Year Age (In yrs. last birthday) (Month, Day, Social Security Number . Korea Hours Davs **Funeral** Months 1 🛣M 2 🗆 F 73 213-23-30<u>21</u> Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State with the Maryland at **Funeral Director** 1 🗌 Yes 2 🔀 No : If item 27 is marked other than "natural", or items 23a or 28a-f s. or other traumatic event, the Medical Examiner must be notified Boyds Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 20841 12719 Fernberry Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No and 2 should be filed within 72 hours after death Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give ģ Specify: Asian Yes 2 No Specify Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) and Mental Hygiene. Elementary/Seconday (0-12) Dry Cleaner Owner 9 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) (unk) (unk) Bong Chool Kim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12719 Fernberry Lane Boyds, MD 20841 19a. Informant's Name/Relationship (Type, Print) 12719 Fernberry Lane Boyds, MD permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Theresa Kim/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/24/2012 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
MO1251 Beverly L. Heckrotte, P.A. Clarksville, M 21. Signature of Funeral Service Licen <u>MD 21</u>029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Cancer Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami ending physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has have some some that the continuation of the funeral Director. Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death ò 9 Unknown ate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🔀 Unknown 5 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 2 🗌 No Yes 2 X No 1 Yes eral Director; After this certificate I filled in by the funeral director, page 26. Place of Death (Check only one) 25. Was case referred to medical Be B examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No Certificate: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at work? 28a. Date of injury Manner of Death (Month, Day, Year) iniury 1X Natural 5 Pending 1 Yes 2 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completed (Check only one 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and

Rockville, MD 20850 1355 Piccard Dr. Coleman 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20c. License number

D37142

December 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Elizabeth Kreczmer Year Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Ar Burnie Aru Baltimore Washington Medical Center al Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 287-20-5933 Months (Month Director 87 1 🗆 M 2 🕱 F Aug 10, 1925 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland Director 10d. Inside City Limits Pasadena be notified Maryland Anne Arundel · 28a-f 1 Yes 2 X No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 7686 Oak Lane. USA Examiner must "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. b and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: 3 X Widowed 4 Divorced White Completed Year or Dates marked other than "natur matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Homemaker 8 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall Distel 0 Catherine Hager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Mrs. Mary M. Thompson (Niece) 27 7686 Oak Lane, Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2012 Atlantic Crematory, LLC 22. Name and Address of Facility McCully-Folyniak Funeral Hone, P.A. Signature of Fune Service Licensee Kevin E Fcker 3204 Mountain Rd., Pasadena, Md. MOO175 23a. Part 1: Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ monl disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any live in the immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

December at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☑ No detached for Month Day Year the 9 Unknown 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 WUnknown 24b. Were autopsy findings available 24a. Was an nas prior to completion of cause of death?

1 Yes 2 No autopsy Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vanorden 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician/ ledical Examiner 1. Decedent's Name (First, Middle,Last) Steven Michael Klein 2. Date of Death Month Day December 21, 2012 4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center 5. Social Security Number 212-60-2294 Usual Residence of Decedent Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10c. City, Town or Location 2. Date of Death Day December 21, 2012 4c. County of Death Anne Arundel 4d. County of Death Anne	teven Klein		State of Maryland / Di 1- For State Registrar	Department of Certificate of			99. No. 2012	4188
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O.C.M.E. December 22, 2012 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	o the Ho ithin 24 I o the Fu		one) 2 Medical Examiner: On the basis of examinal	owledge, death occurr ition and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as stated and place, and due to the	d. cause(s)
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:			hite
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薑	permit. Page Department of Important: If any injury or once.		4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Fune ☐ Service Incense	96	-	fts Regist: 2. Name and Addre			ifts Regis	
Ba	permi Depar Impo any ir		1	30				•	, Hanover,	•
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the	death. Do not ente	er the mode of dyir	ng, such as cardiac	or respirat ry arr	est,	Approximate Interval Between
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68			IF FEMALE:	in white the						-
P.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	elivery Day Year
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/ita		Be C	25. Was case referred to medical examiner?	·	-	Lou	26. Place of Death	(Check only one	e)	
of	Physic this ce ral dire	၉	1 Yes 2 □ No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outpatien		4 - Ivursing Ho		ence 6 Other (Spe	ecify)
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifical completely filled in by the funeral director,	ledical Ce		sician: To the best of miner: On the basis of example and manner stated	amination and/or in					
	To the within To the sompi	Me	29b. Signature and title of certifier		_	29c. License		2	9d. Date signed (Mor	th, Day, Year)
	(D667	166	D	ecember 11	,2012
	(d)		30. Name and address of person who c	ompleted cause of deat	h (Item 23a) (Type,	Print)				
	4		HANS FORIAN PUTIGEN 31. Date filed (Month, Day, Year)	32. Regis#ar's	Signature		4940 E	astern Av	enue, Baltim	ore, MD, 21224
	Sta Registr	_		2012 Pagistal's	oignature 1	books				

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 21, 201 Vonn e Decembe 04:57AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Balhmore HOS NIA 18) ta 0 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Director 1 M 2 V 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Nes 2 No more 10e. Street and Number 10g. Citizen of What Country? 2111 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. and Mental Hygiene, Is marked other than "natural", or I Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Page 1 and 2 should be filed within 72 hours after Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homema Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ VIna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau once. Hills 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility . Howell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such 4 cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physicien end I for use as the burial-transit or Attending Physician: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No Month Day eral Diractor: After this certificete hes been signed by the a filled in by the funeral director, page 2 should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 21 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 21 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident s after death Investigation 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours of To the Funeral Discompletely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier RES-000 ecember 21,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Hosm ray okum sinal 31. Date filed (Month, State Registrar

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			For State Registrar	State of Maryland	-	tment of H ificate of I			giene Reg. No		2	4189	0
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	/Medio		4a. Facility Name (If not institution, give	street and number)	4	-	Location of Death	ecember	21 4c.	County of D		^	
angeres "			Med Star Harbor Mo 5. Social Security Number 6. Sec	04 pita 0x 7. Age (In yrs. Ia	est hirthday)	Baltima If Under 1 Year		8. Date of Bir	th	9	N//	ce (State or Fo	reian
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	death	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. Wa		ispanic Origin? (Specin, Mexican, Puerto F	cify Yes or No)- \(\)	14. Race - A	merica	n Indian,	
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Experien must be rediffed at	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		Yes 2 No	Specify:	ican, ecc.)		Black, W	Sic	en)	
21215-0036	"natur	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Deceder	nt's Usual Occup	ation during most of working	g	16b. Ki	nd of Busine	ss/Indu	stry	
212	d withii glene. er than	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	He		vite		I	omes	SHIC	ر 	
and	be file ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last)	Sile			18. Mother's Name	(First, Middle	, Maiden	Surname)			
Maryland	should ind Mei marke umatic	1º	19a. Informant's Name/Relationship (Ty	iype. Print)	19b. Mailing	Address (Street	YUUN and Number or Rural	Route Numb	الب. er, City o	r Town, Stat	e, Zip (Code) 2104	13
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction to other traumatic event, the Medical Exaction to other traumatic event, the Medical Exaction to other traumatic event, the Medical Exaction to other traumatic event, the Medical Exaction to other traumatic event, the Medical Exaction to other traumatic event, the Medical Exaction to other traumatic event, the Medical Exaction to other traumatic event, the Medical Exaction to other traumatic events.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cemation 3 ☐ F 4 ☐ Donation /5 ☐ Other (Specify)	Pomoval from State Cel	ace of Disposit metery, crema MOHOYI	tory or other place	(i) 12/22	2612	1-to	Cation - City	or low	m, State	
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			30. Name and address of person who co	MD ompleted cause of death (Item)	23a) (Type. Pr	int)	sool ver Spring		Uccem	ber Zegos	21	2012	
			Dias 2400 16808	Hoffman Manor	Dr	Sil	ver Spring	M	D	20905	5		
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Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert George Lambert December 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Senator bob Hooper Hospice House Forest Hill Harford If Under 1 Year If Under 24 Hrs.
Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 333-16-8916 1 XM 2 F Director 89 Jan.13,1923 Illinois 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland od other then "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Maryland Harford Bel Air 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1219 Sparrow Mill Way 21015 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health end Mentel Hygiene. Importent: If item 27 is marked other then "natural", or items 2000s. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian /ペン/ペン/ シー / : サひ チバイBaltimore, Maryland 21215-0036 Armed Forces? 1942— 1 X Yes 2 No 1946 If Yes, Give Year or Dates. Black White etc. <u>۾</u> 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Lumber Wholesale Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Lambert Hattie Charlotte Maas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 Sparrow Mill Way BelAir , Maryland 21015 Susan Quinn / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/24/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. Ctephanie Custer Frederick Road Baltimore Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlel-trensit Dause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 N 2 🗆 No 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗆 Residence 🚱 Other (Specify 2 No ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James Samue1 Landrum December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 3001 Hydes Harford Road Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 232-68-1764 1 X M 2 🗆 F 68 Dec. 31. 1943 West Virginia 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director 1 - Yes 2 7 No Harford Maryland Hydes 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3001 Harford Road 21082 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 X Married "naturai", or þ Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Fork Lift Driver Factory Be ₹ * 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 2 Leonard Landrum Vinnie Cochran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Amy Sheets / Daughter 3001 Harford Road, Hydes, Maryland 21082 item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
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Important: If ite
eny injury or ot 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/27/2012 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland In 21. Signature of Funeral Service Licensee ALVSON K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Cause (Disease or injury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day 5 Other (specify) 1 Yes 2 No ed by the a detached i 9 Unknown certificate has been signed I irector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h performe death?
1 Yes 2 No Yes 2 A N by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Directornilles of the Funeral Directornilles of the Funeral Directornilles of the Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Fu Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 2012 address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ John Patrick Landon 2012 9:50 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 17 1931 6 Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours Country) Director 212-28-2233 1 X M 2 □ F 81 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show yi luluy or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director MD Carrol1 Eldersburg 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2116 Carroll Dale Road 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Korea
If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) warehouse worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Albert R. Landon Mary M. Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne Schwartz (daughter) 2116 Carroll Dale Dr., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 1-2-13 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel Dary Jarght 2 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease Injury Victorial Industrial Cause of Cause Injury Victorial Industrial Cause of Cause Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Injury Victorial Examine Due to (or as a consequence of) burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ۵| 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Framiner: On the basis of examination and/or investigation, in my pointing, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to puscés) and manner as statu 29b. Signature and title of certifie 29c. License number 0

Registrar

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	or 28		MD BALTIMO 10e. Street and Number	JKE ·	TORNER	10f. Zip Code		-	10g. Citizen of	What Cou		
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Divis	pepital or At hours after of inere! Directly filled in by		4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	") +ts	me		ROAD, I	(Street and Numb wn, State) 113 TURNER'S	AVON STAT	BEACH ION, MD	
29a. Certifier (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							use(s) and manner stated.					
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	HYSM		30. Name and address of person who com	npleted cause of death (Ite	em 23a) (Type		O _L	Bn.		- / -		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 41895 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12145 AM 2001 Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and Examiner 4c. County of Death 1934 Himore oad Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 218-62-5012 Months Min. Director 1 M 2 □ F 919 if item 27 is marked other then "neture!", or items 23e or 28e-f show or other treumatic event, the Medical Evaning must be notified at 10c. City, Town or Location within 72 hours efter death with the Meryland 10d. Inside City Limits Director 1 🖭 Yes 2 □ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. Completed by Yes 2 No Specify: Black Marylahd 21215-0036 permit. Pege 1 and 2 should be filed within 72 hours eft. Department of Health and Mantai Hyglene. Importent: If Item 27 is marked other then "neturel", eny injury or other treumatic event, the Madical Even once. 1 ☐ Yes 2 ☑ No Specify: If Yes. Give 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) (0-12) College (1-4 or 5+) river Be 18. Mothe 2 Name/Relationship (Type, Print) Number, City or Town, State, Zip Code) Baltimore, MD 21229 Koad 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, ca Baltimore, YND Nor uneral 21. Signature of Funeral Service License Services 23a. Part 1. Enter the disease, or complications that caused shock, or hand failure. List only one cause on each line. disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): effer death.

Director: After this certificate has been signed by the ettending physicien end d in by the funeral director, page 2 should be detached for use as the burlei-trensit To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours effer death.

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Live Birth 2 Fetal death
Pregnant at time (1) 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 € No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of the 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Unatural 5 Pending 2 Accident
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Z pura Z		Antoine Anthony-Son 4 Vernon Hill Court Catonsville, MD. 21228 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State											
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Division tal or Attendin s after death. al Director: A	28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d Describe how in 28d De								et and Number or Rural Route Number, City				
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To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner:	n: To the best of my kn On the basis of examina									se(s)	
E.3E.8	3	29b. Signature and title of certifier	and manner stated.			29c. Licens	se number		29d.	Date signed	(Month Di	av Year)	

State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 ΡМ Karen Elizabeth Lewand 2012 10:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 324 Rossiter Avenue Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/19/1945 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours ^{untry)} Michigan Director 1 □ M 2 1 F 363-50-3612 67 Usual Residence of Decedent 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location irector 10d. Inside City Limits 1X Yes 2 ☐ No MD Baltimore 喜 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 324 Rossiter Avenue 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian. 10:25 р.ш. Black, White, etc. 1 Never Married 2 Married ğ 1 Yes If Yes, Give Maryland 21215-0036 2 No 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) American Institute Of 5+ Executive Director Architects Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) eonard Schultz Elizabeth Stroinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 20, Robert Lewand / Husband 324 Rossiter Avenue, Baltimore, MD 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility W. Maisho 1 Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) BREAST CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran that initiated events Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No 5 Other (specify) Pregnant at time of death To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate 1 ☐ Yes 2 ☐ No 2 X No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ည 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident Investigation 1 ☐ Yes 2 ☐ No 24 hours after deat Funeral Director: 3 Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the 3 🗓 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of contifier 29d, Date signed (Month, Dak, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. MD 21093 TIMONIUM, 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

2012

DECEMBER

KAREN LEWAND

	For State	State	or ivial ylari				Mental Hy	_	0.1.0	1 100								
	Registrar 1. Decedent's Name (First, Middle	(ast)		Cer	tificate of	Death	2. Date of De	Reg. No.	U12	4 18								
ı	John Po-Pei I	,						er 23,	201°2	3. Time of Dea 9:05 E								
ŀ	4a. Facility Name (if not institution,		nber)		4b. City, Town,	or Location of Deat		4c. County of Death										
	5313 Wapakoneta				Bethesda				ntgom									
ľ	5. Social Security Number 570–62–1272	6. Sex 1 🏖 M 2 □ F	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.				hplace (State or Foi intry)								
١	Usual Residence of Decedent	1 23 W 2 🗆 1	87	Yrs.			May 1	, 1925	Chi	na								
Director	10a. State 10b. County		10c. City	, Town or Lo		_				10d. Inside City Li								
ŀ	MD Monto	gomery			Betheso 10f. Zip Code	la	1 ☐ Yes 2 🛣 No											
	5313 Wapakoneta	n Poad				0816		d Sta	-									
ľ	11. Marital Status		edent Ever in U.S		Vas Decedent of I	Hispanic Origin? (S an, Mexican, Puert	14. 1	Race - Ameri	ican Indian,									
Completed by Funeral	1 Never Married 2 Marr		2 🔀 No		Yes 2 N			Black, White										
ŀ	3 Widowed 4 Divorced	Year or D.		ent's Usual Occu		Specify: Asian 16b. Kind of Business/Industry												
ŀ		st grade completed, College (1		(Give I		during most of wor	rking	Tob, Kind d	i business/ii	ndustry								
_	Elementary, decordary (0 12)	4	4 01 047	Inter	preter			Feder	cal Go	vernment								
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk)									a <i>m</i> e)									
ŀ	(unk) 19a. Informant's Name/Relationsh	ain (Tuna Print)		400 14 10	(unk)	(unk)	-18-4-14-4	O'1 - T	04.4. 7	(ur								
l	Mary Jane H.		Wife		Wapakon	and Number or Ru	Bethesd			Code)								
t	20a. Method of Disposition		20b. P	ace of Dispo	sition (Name of natory or other pla		Date	_	on - City or 1	Town, State								
	1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S					tory 12/	26/2012	Wood	bine,	Maryland								
	21. Signature of Funeral Service L	icensee	/	<i>G</i> G	Name and Addr	es cremati	on Serv	ice P.). Box	784 .e, MD 21								
+	23a. Part 1. Enter the disease, or	complications that							CSVIII	Approximate								
l	shock, or heart failure. List o Immediate Cause (Final			ı II.	+0	10				Interval Between Onset and Deatl								
disease or condition resulting in death) a. Concestive Hear! fa, Ture Due to (tras a consequence of):																		
Sequentially list conditions, b. D. Lated Cardiomyapathy																		
if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying																		
	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consequ	ence of):														
		L.																
ŀ	IF FEMALE:	1																
	23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregnar Birth 2 🗆 Fetal	death 3		су		23d. Date of delivery										
	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unki	nant at time of d	eath 5∟	Other (specify) _				Month	Day Year								
ŀ	Part II. Other significant condition	ns contributing to c	leath but not resu	ulting in the u	nderlying cause g	iven in Part I.	23e. Did	obacco use c	ontribute to	the cause of death								
	Med	astatio	lung	cune	er		1 🗆	Yes 2 No 3 Probably 4 Unknown										
1	, 40,	VUS INVIVE				is an 24b. Were autopsy findings available												
1		W 100 100	_					24a, Was an										
1		103 pm					auto perfe	psy ormed?	prior to co death?	_								
	25. Was case referred to medical examiner?				26. F	lace of Death (Che	auto perfo 1 🗆 Yes	psy	prior to co death?	ompletion of cause								
	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2 🗆 I	ER/Outpatien	26. F t 3 □ DOA Otl	ner: 4 Nursing H	auto perfici 1 ☐ Yes sck only one)	psy prmed? 2 No dence 6 0	prior to condeath? 1 Yes Other (Specification of the condeath)	2 🗆 No								
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	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin Investig 3 Suicide 6 Could referred to medical examiner? 2 Accident Investig 4 Homicide determiner determiner to medical examiner.	Hospital: 1	Inpatient 2 of injury th, Day, Year) of Injury - At horing, etc. (Specify) sest of my knowle	ER/Outpatien 28b. Time of injury me, farm, stre edge, death c and/or invest	26. F t 3 DOA 28. Inju wor 1 vet, factory, office	er: 4 Nursing F y at k? Yes 2 No ne, date and place, on, death occurred the time, date and g	auto perficience of the perficience of the perficience of the perficience of the perficience of the perficience of the perficience of the perficience of the perficience of the perficience of the perficience of the performance of the performa	psy psy psy psy psy psy psy psy psy psy	prior to c. death? 1 Yes Other (Specificurred mber or Rura anner as sta due to the c. dd manner as	2 ☐ No al Route Number, ated. ause(s) and manner stated.								

State

May 6095 Marshalee Dr., Ellandee, MD, 21075

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charls Who Howerson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PECEMBER 21 2012 Nancy Lee Loughry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deatl CILEN BURHIE BAUTI MORE WACHINGTON MEDICAL GENTE ANNE A Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Director 220-38-8117 1 □ M 2 🖾 F 1942 23, Maryland Usual Residence of Deceder 70 Mar 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medicel Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Pasadena MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 United States 7729 Suitt Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, δ 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give land 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic once. John Thomas Zook Alice Mae Doenges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD 21122 Benner / Daughter 8332 Dock Rd. Lynda Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 12/26/2012 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 25a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Quset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final OBSTRUCTIVE FULMUNAP Physician/ CHIPOHIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of, the Hospital or Attending Physicien: The lew requires that the death certificate be executed inding physician and use es the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 5 Other (specify) g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗂 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatu elembe/ ted cause of death (Item 23a) (Type, Print) me and address of person who compl

State Registrar 31. Date filed (Month, Day, Ye

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12-0	9664	
Guy	Edward Lambert	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	1- For State Certificate of Death Reg. No.								
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Guy Edward Lambert 2. Date of Death Month Day Year December 19, 2012	3. Time of Death 1316 hrs							
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8altimore N/A								
Funeral Director									
Maryland 28a-f shrw any d at once. ector	Usual Residence of Decedent 10a. State	10d. Inside City Limits 1 XYes 2 No							
th the Maryland 23a nr 28a-f shu notified at once. 31 Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Court 21225 U.S.A.	rtry?							
5 72 hours after death with the Maryland n "natural", or items 23a nr 28a-f shu eal Examiner must be notified at once leted by Funeral Director		can Indian, Black, hite							
5-0036 led within 72 hours is Hygiene. cother than "natura the Medical Exami									
be fi	George E. Lambert Shirley Dowler								
MD 21 d 2 should d 2 should lth and Me n 27 is ma numatic co	Bonnie Dickey / sister 4 North Betty Street Laurel, Maryl	and 20724							
Baltimore, MD 21 bernit. Pages I and 2 should Department of Health and Me Important: Uitem 27 is ma injury ar other traumatite v	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 12/24/2012 Baltimore 22c. Name and Address of Facility 20c. Location - City or 12/24/2012	e, Maryland							
Balt Permit Depart Impor	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	yland 21225 Approximate Interval							
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N N N N N N N N N N N N N N N N N N N	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Mo December 20, 20								
\$	30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223								
State Registrar									

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ December 23, 2012 Edythe Katherine Mason 8:00 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2525 Pot Spring Road Baltimore County Unit K506 Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Days 218-14-8674 Hours 89 Director 1 □ M 2 🌣 F Baltimore, MD. Aug. 08,1923 Usual Residence of Decedent an "natural", or Items 23e or 28e-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland Director Timonium Maryland Baltimore County 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road Unit K506 21093 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give 00~A.M. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify: 3 x Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore County Board College (1-4 or 5+) Elementary/Secondary (0-12) of Education Secretary N/A event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hellen E. Sigman permit. Page 1 and 2 should be file Department of Health and Mental Filmportent: If Item 27 Is marked o eny linjury or other traumetic eve 90.68. Harry C. Maempel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1522 Charmuth Road Lutherville, Maryland 21093 Mrs. Sharon L. Davis Daughter 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Harford County Forest Hill, Maryland Date Evans Funeral (nace) Cremation Services, Inc 1 Burial 2 Cremation 3 Removal from State Wednesday 4 ☐ Donation 5 ☐ Other (Specify) Dec.26,2012 of Funeral Service Licensee Jeffrey L. Gair, Sr. CFSP2. Name and Address of Facility ves Funeral and Cremation Center, P.A.
Peacetul Alternatives Funeral and Cremation Center, P.A. 21. Signate 2325 York Road Timonium, Maryland icht 1. Inter the disea of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CINOM disease or condition resulting in death) Medical Due to (or as a consequence of): ¹Examiner Sequentially list conditions. Examine Due to for as a consequence of: To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funsel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Edythe Mason Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 🗷 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ည 1 🗌 Yes 2.2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) Type, Print) MD 21093 2300 Dulaney Valley Road, Timonium, Ernestine Wright D31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MUETICAL 0245 M Month 12 Physician/ hay Rolinda Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death (Entile 10RRO 11 1tospital 05202011 Wastminster Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral Director** 1 - M 2 07 la or 28a-f show be notified at should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Brooklyn Park 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a c c must b Funeral 21225 United States 611 Wood Street items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No n "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced White Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natuiury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Fiscal Clerk State Of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Dortha E. Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas C. Nelson/ Son 401 Linda Ave, Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot X Aurial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Other (Specify) 12/27/2012 Brooklyn Park, Maryland Cedar Hill Cemetery 21. Signature of Autorial Servic License 22. Name and Address of FacilityKirkley-Ruddick Funeral Home 421 Crain Highway SE, Glen Burnie, Maryland 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ 500615 disease or condition Medical resulting in death) **Examiner** URRHOSK Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events RESPIRATORO the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Intracosoucie issuminated Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KENGI m455 1 Yes 2 No 3 Probably 4 Unknown thrombog topinia, VIALHOSIS, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No DORTON hupathoo After this certificate 1 Yes 2 No Be 25. Was case re rrred to medical 26. Place of Death (Check only one) examiner? 2 X No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D0069314 ID and address of person who comp ause of death (Item 23a) (Type, Print) Destra O 10- Tigily my 31. Date filed (Month, Day, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0532AM NE 012 Medical Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospt ou ar ounte Genoral If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Months Hours Director 201-32-2291 1 M 2 D F October 15,1940 Pennsylvania 72 or items 23a or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Columbia Maryland Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 10075 Quantrell Row 21046 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X No ģ 1 Never Married 2 Married Maryland 21215-0036 th and Mental Hygiene.
It is marked other than "natural", o traumatic event, the Medical Exerc. 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) NSA Mathematician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Dirner Francis McNelis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10075 Quantrell Row Columbia, Maryland 21046 (Wife) Maria McNelis Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State ortant: If if injury or o cemetery, crematory or other place, Hanover Township, PA 12-29-2012 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 21. Signature Furleral Service Licens 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, Maryland 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one contents the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one contents the caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Mouro disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due tulor as a consequence of. the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-trans that initiated events resulting in death) Last Physician/Medical 1001 Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed⁴ 2 No filled in by the funeral director, 25. Was case referred to predical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 □ No 1 Inpatient 2 ER/Outpatient 3 IDOA 은 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner Death Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending s after death. Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie License number 29d. Date signed (Month, Day, Year) 0 on who completed cause of death (Item 23a) (Type, Print) tho CEDAR 32. Registrar's signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41905 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Date Month 2. Date of Death 3. Time of Death Physician/ Gertrude Bradunas Madden Dec 2012 11:05pm^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore Social Security Numbe **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min **Director** 217.07.1614 1 M 2 XF Yrs Usual Residence of Decedent June 20, 1917 MD 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral and 2 should be filed within 72 hours after death with 709 Maiden Choice Lane. RG401S 21228 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony J. Bradunas Mary Anna Zitkus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Michael Madden- son 5409 Silent Moon Run. Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important; If ite any injury or oth 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cemet 12/28/2012 Dundalk, MD of Funeral Serio Licensee of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, MD 21228 21. Signature MO1050 101 tade 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Endstage Medical resulting in death) Due to (or as a sequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buris Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has autopsy page this certificate 1 Yes 2 funeral director, or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Matural 5 Pending work? 2 Accident 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Ms

State Registrar

IDV

30. Name and address of person who

Michael K. / 31. Date filed (Month, Day, Year)

REC 2 7 2012

Maiden Choice LN. Catorsville

2/228

completed cause of death (Item 23a) (Type, Print)

32. Registrar's aignature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #5, per fh, g934 12-27-12 sm
State of Maryland / Department of Health and Mental Hygiene 41906 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ DANIEL MICHAEL MARTINO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ALCHRIST HOSPICE RVO CARE COLUMBIA HOWA If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Director 1 **X** M 2 □ F 1920 HPR 20 PENNSYLVANIG 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show traumetic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director YKESVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral SA MARUIN 6616 21784 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry COMMERCIAL College (1-4 or 5+) Elementary/Secondary (0-12) ARCHITECT BUILDING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MARTINO MICHELE of Health and Doild both the strand Meritem 27 is mark rother traumetic WIFE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6616 MARVIN AVE SYKESVILLEMO 21784 MARGARE MARTINO Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 artment of H ortant: If ite Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/28/2012 DUTH CAMOU CLEM WINFIELD, MO 22. Name and Address of Facility \ N WMBNN IHA MON Co. . Signature of Funeral Service Licenses SYKESVILLE BO EWERSBURGIND 21784 23a. Part VEnior the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition promper Jal Medical resulting in death) Due t (or as a consequence of): Examiner CGCILO postcidina Becompos 7,3013 Sequentially list conditions, Examine Due to (or as a consequence of) If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ate has been signed by the ettending physicien and page 2 should be deteched for use es the burlel-trensit or Attending Physician: The law requires thet the death certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000 No After this certificate has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner?

1 Yes 2 26. Place of Death (Check only one) 8 Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) <u>۾</u> 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) COMPRE Name and address of person who completed cause of death (Item 23a) (Type, Print) an significa 6336 ceder lane 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2012 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 | 2 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Ce	rtificate o	f Death			Re	eg. No.		
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lical Exam	iner	John Stuar		_					Month December	Day Year r 19, 2012	1 14	143 hrs
)		4a. Facility Name (if not institu 3020 Main Street A		umber)		4b. City, Town, o Mancheste		f Death		4c. County of Carroll	Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea		24Hrs	8. Date of Bir	th(MM/DD/YYYY)	9. Birthplace	e (State or
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Aaryland 28a-f show I at once .	용	10e. Street and Number				10f. Zip Code			11	0g. Citizen of Wha	t Country?	
th the Maryland 23a or 28a-f sho notified at once.	Director	2020 Main	C+ Ant	D			102			U.S.A.		
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2 should be filed within 72 hours after death with the Maryland hand Mental Hygien Mental Hygien 27 Ti unarked other than "natural", or items 23a or 23a-f she ransite event, the Medical Examiner must be notified at once mastic event, the Medical Examiner	Funeral	1 Never Married 2 X	Married Armed F	orces?		es, specify Cuba				White,		
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ould d Mer s mar	၉	19a. Informant's Name/Relation			1.0	- •				nber, City or Town,		
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permit. Pages I a Department of Ha Important: If it injury or other t	1 3	21 Signature of Fun al Servi	ce Licenta	37720					hardt	Funera	l Cha	pel P.
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Hospital or Atteoding Physician: The law requires that the death certif Let hours after death. Fluoral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as	Physiciar	1 Yes 2 No 9 U	Jnknown g Unkr		eath 5 Of	ther (Specify)						
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or Atte after dea Director	Certification:		ould not be			et, factory, office	ouilding, etc	. 2	8f. Location (8 or Town, S	Street and Number state) 3020 Ma	or Rural Roi Lin St	te Number City Apt B
To the Hospital or A within 24 hours after Yo the Fuoeral Dire completely filled in b		4 Homicide		Multi-I						ter,MD.		
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()	≥	29b. Signature and title of cert	mer /	mi		29c. Licens				29d. Date signed		y, re ar)
34	1	Melin	Browl!	110		U.C.	M.E.			December 2	0, 2012	
		30. Name and address of pers		•	•							
		Melissa Brassell, M	O Assistant Me	edical Exami	iner 900 V	/. Baltimore S	street, Ba	altimore	e, MD 2122	23		
	tate		ir) 32. F	Registar's Signat	ture							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Loyce S. Pitts Mayo 2012 3:55 P. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 9200 Edwards Way #609 Adelphi Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If I Inder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Hours 438-42-1759 **Director** 1 □ M 2🏋 F Yrs. 04-09-1927 T.A Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director r 28a-f sh notified a MD Prince George's Adelphi 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be items 23a Funeral 9200 Edwards Way #609 20783 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and 2 should be filed within 7. Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Math Teacher Texas Public Schools 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Loyce Pierre Wesley Pitts, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9200 Edwards Way #1114 Adelphi, MD 20783 Patsy Pitts-Royster item 2 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1
Department of
Important: If it
any injury or o ō 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 12/14/2012 Landover, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW, Washington, DC 20011 rt 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death ock, or heart failure. List only one cause on each line shock, or heart failu Immediate Cause (Final disease or condition Physician/ ementio Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 2-XNO 1 \square Yes ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural 5 Pending M Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2

Registrar

DHMH 17 Rev 06-2011

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

180

32. F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of	Marylan		artment of F tificate of D		Mental Hyg	iene eg. No.	12	41909	
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Funeral Director	_	Iorien Nursing 8 5. Social Security Number 6. S 219-18-2250		Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,		ace (State or Foreign y)		
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036 's after deat ral", or iten	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 1 Yes 2 If Yes, Give Year or Dates	s? □ No	lf	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2 🔀 No	n, Mexican, Puert	oecify Yes or No- o Rican, etc.)		e - America k, White, e		
21215-0036 within 72 hours after giene. er than "natural", o the Medical Exam	Completed	15. Decedent's I (Specify only highest gi Elementary/Secondary (0-12)	ducation		(Give k	ent's Usual Occupa ind of work done d NOT use retired)	luring most of wor	king	16b. Kind of Bu	siness/Ind	ustry	
Maryland 2 2 should be filed wi th and Mental Hygie 27 is marked other traumatic event, il	To Be (17. Father's Name (First, Middle, Last) John E. Murphy		Salesma	18. Mother's Nar	Building Supp 8. Mother's Name (First, Middle, Maiden Sumame) Margaret Hube						
Mary		19a. Informant's Name/Relationship (Type, Print) Anna L. Murphy/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Part of Dartmouth Rd Columbia, MD 21045									ode)	
Baltimore, IMaryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from Sta	to C	lace of Disposemetery, cremement. Cer	ition (Name of atory or other place iter of M	e) D 12/	Date /23/12	City or Tov	D		
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5 w _{it}		29b. Signature and title of certifier	reple M	29c. License number 29d. Date signed (Month, Day, Yea MD 29d. Date signed (Month, Day, Yea PECEMBER 2 Ise of death (Item 23a) (Type, Print) Ellectric Cuty 210 4						na		
		30. Name and address of person who shall male	Suple	death (Item		nt) eelot (non E	llecoti	Cety	210	72	
Sta Registra	te ar	31. Date filed (Month, Day, Year), DEC 2 7 20	12 34. Regis	trar's Signat	· par	Kel				-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gerald David Morgan Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Bal 00 ose a mo Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 212-44-5236 Director 1 X M 2 □ F 68 Maryland August 24,1944 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 9444 Ridgley Ave. USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Morgan Geral d Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify White "natural", Specify: 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Master Carpenter Construction 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerald Morgan Sr. Ruth Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Morgan Wife 723 213th Street, Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 XBurial 2 Cremation 3 Removal from State Rosedale, Maryland 万 ☐ Other (Specify) 28, 2012 Gardens of Faith Cem 4 Donation 21. Signature of Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examir Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the as attending IF FEMALE: se 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Dav Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 4 ☐ Pregnant 9 ☐ Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 s autopsy performed? Yes 2 this certificate 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 24 hours after death.
Funeral Director: After this etely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hou

To the Funer

completely file 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1)006328 Name and address of person who completed cause of death (Item 23a) (Type, Print) 000 Franklin 32. Registrar State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#19a, perFH, G935, 1/11/2013, WS
State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 2:16 PM Vickie Mangini 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City. Town, or Location of Death Gilchrist Hospice Center Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) 01/13/1928 Months Days Hours Min. Country) Pennsylvania Director 1 □ M 2 🖰 F 028-16-5020 84 Yrs Usual Residence of Deced th and Mental Hygiene. 27 is marked other then "naturel", or items 23a or 28a-f show traumatic event, the Madical Examinating the partitled at 10a. State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4324 Roland Avenue 21210 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke eny Injury or other traumatic Ralph Napoli Elvira D'Andrea 19a. Informant's Name/Relationship (Type, Print)
Son-in-Law
Ken Winkler / Sister-in-Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4324 Roland Avenue, Baltimore, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 12/26/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Failure to thruse disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Demente Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and thed for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) Month Day Year sate has been signed by the same page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpuce 1 🗌 Yes 2 📈 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D72139 December 25th 2012 MD 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) 6701 N Charles Street Suite 4105 Baltimore MD 21204 SYED ABBAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Pay 19 2 PT 2 Garry Monroe Myers 4:40 Pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Fredrick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) 08/18/1959 Country) Maryland 11∆ M 2 □ F Director 218-72-2682 Yrs Usual Residence of Deceden er than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ¹X☐ Yes 2 ☐ No MD Washington Keedysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3622 Trego Mountain Road USA 21756 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Mechanic Automotive 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Alton Myers, Sr. Dorothy Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Marie Yingling / Daughter 309 Roberts Mill Road, Apt. B, Taneytown, MD 21787 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or oth 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/22/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, ediate Cause (Final ase or condition Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ST elevation myocordial 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an ours after death.

eral Director: After this certificate I filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No. Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 30. Name and address of person who come eted cause of death (Item 23a) (Type, Print) FMH 400 W. Seventh SA Marius 31. Date filed (Month, Day, Year) State

X DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20/2 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ulura LARE Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 212-32-704 Min. **Director** (YURVIAM) 28a-f shov 10b. County 10c. City. Page 1 and 2 should be filed within 72 hours after death with the Maryland Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No TIMORE 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 2 No Yes Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLOCK Specify "natural" 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonce. Elementary/Segondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State AUSTRUNK 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Lice fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Can disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death igned by the attendin be detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at work? ___1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniurv Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number

Registrar

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AICR OKA ENR 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DUNDALK OMBARDY BALTIMORE DRIVE 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 XM 2 □ F 12-4-1924 MARYLANI 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f shoreny injury or other traumatic event, the Model Execular must be notified at 10c. City, Town or Location 10d. Inside City Limits Director WNDALK 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 OMBARD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?.

1 Yes 2 No
If Yes, Give Black, White etc 1 Never Married 2 Married δ Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DA/CSMA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ 1A/er 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-29-2012 21. Signature of Funeral Service Licensee NNINO 23a. Part 1. Enter the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or he at before cause on each line.

Immediate Cause Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner ca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Dav 23e. Did tobacco use contribute to the cause of death? signe I be o þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy CNH hx on certificate 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Division of Vital or Attending Physician: æ 26. Place of Death (Check only one) examiner? 2 X No Other: |@ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 066566 2012 30., Name and address of person who completed cause of death (Item 23a) (Type, Print)/ 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 Charles Louis von Nordeck 2012 9:16 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) 01/12/1946 Country) Maryland 110 M 2 □ F Director 217-46-2113 66 it than "neturel", or itams 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Y Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 10 Stoneridge Court 21239 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 4 Force If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1963-67 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Representative Wholesale e 1 and 2 should be filad wit of Heelth and Mental Hygie If itam 27 Is markad othar or othar treumatic avent, II Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Royden von Nordeck Elizabeth Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Rich von Nordeck / Wife 10 Stoneridge Court, Baltimore, MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) parmit. Page 1 a Dapartment of H Importent: If its any injury or ot Date 20c. Location - City or Town, State Page 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 12/27/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician SQUAMOUS CELL TONGUE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the deeth certificate be exacuted Due to (or as a consequence of): resulting in death) Last physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year signad by the at d ba detached f 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24 hours after death.
• Funeral Director: After this certificate has been si etely filled in by tha funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 2/X No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical To tha Hosp within 24 hoυ To the Funer completely fi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Such 4105 Baltimore MD 21204 6707 N Charles ABBAS 31. Date filed (Month, Day, Year)
DEC 2 7 2012 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

			For State Registrar	State of Maryl		artment of F			iene eg. No. 2012	41917		
¥	Physici /Medic		1. Decedent's Name (First, Middle, L	155				2. Date of Dea Month		3. Time of Death 5: 10 AM		
	Examin		4a. Facility Name (If not institution, go	ive street and number)		4b. City, Town, o	r Location of Dea		4c. County of Dea	ath		
-,1,,,,,,	Funeral Director		Social Security Number 6.		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Bi	rthplace (State or Foreign ountry) exas		
	aryland show dat	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									
	vith the M. or 28a-f	Directo	10e. Street and Number	gomery	Gaither	10f, Zip Code	,	1	0g. Citizen of What C	1 ☐ Yes 2 ☐ No country?		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at	Funeral Director	333 Russell Av	12. Was Decedent Ever i Armed Forces?	in U.S. 13.	20877 Was Decedent of H If Yes, specify Cub		Specify Yes or No- rto Rican, etc.)	USA 14. Race - Am Black, Whi			
215-0036	hours aft tural; or al Exami	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's I	1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 🙀 No dent's Usual Occup	Specify:		Specify: W			
-GLZ12	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest g	College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)							
yland	ld be filed lenta! Hygi ked other ic event, ti	To Be C	17. Father's Name (First, Middle, Las Robert Hill Wil				18. Mother's Na Lena J	me (First, Middle, i				
Z	nd 2 should be alth and Menta 27 is marked on ir traumatic ev	-	19a. Informant's Name/Relationship (Type. Print) Evelyn Purdum - daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 12601 Molesworth Dr; Mt. Airy, MD 217									
Baitimore,	Pages 1 a nent of Hea int: If item iry or othe	l li	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)									
Balti	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic esone.	21. Signature of Fineral Service Licender Board Ronal dy S. Wade, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD										
ኢ	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List onl Immediate Cause (Final disease or condition		1	1-	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a con		ation -t Fail	we			Many Years Many Years. Few Days.		
	be executed ician and burial-transit.	Examiner										
68/60 ,	e ys	ical										
. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 Unknown 1 23c. If yes, outcome pf pregnancy 23d. Date of de									
as, r	uires that signed by d be deta	þ	Part II. Other significant conditions Atrial Fibrillat		1 0	nderlying cause glv		23e. Did tol	,	to the cause of death?		
	The law requires that the rate has been signed by the page 2 should be detache	Completed	Peripheal Eden	a (Severe)		3		24a. Was a autops perform	sy prior to	uutopsy findings available completion of cause of		
or vital	hysician: nis certific I director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Oth	or:	ath <i>Check onl on</i> Home 5 ☐ Reside				
JIVISION O	ending Plath. St.: After the funeral		27. Manner of Death 1		28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe ho	ow injury occurred			
Ĭ	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certification the Funeral Director, and the funeral director, sompletely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	building, etc. (Sp	ecify)			City or Town				
	the Hosp in 24 hou the Fune ipletely fil	Medical										
	vith To T	Σ	29b. Signature and title effectified 29c. License number 29d. Date signed (Month, 12 13 12							th, Day, Year)		
			30. Name and address of person who Nilay Thake	D.D. 1502 S	. Main	- 1	t. Arry	MD 217	71			
	Sta Registr		31. Date filed (Month, Day, Year) NFC 2 7 20	22. Registrar's Si	ignature A Sax	Ke	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 4 1918 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2012 Frank Lee 0akley 10:00 RM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death North Arundel Health & Rehab. Center Glen Burnie Anne Arundel Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 217-18-9701 Director 1 M 2 □ F 94 Yrs 10/05/1918 North Carolina show 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is merked other then "netural", or Items 23a or 28a-f shor other treumatic event, the Medical Evarians must be nettined at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Clermont 1 🗌 Yes 2 🔯 No FI. Lake Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34715 921 South Main Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1XXYes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Chief of Police Law Enforcement yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nora William Jackson 0akley Kasey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Cynthia G. Oakley /Daughter 921 South Main Avenue Clermont, FL 20b. Place of Disposition (Name of cernetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pege 1 e
Department of H
important: If Ite
any injury or ot
once. 1 Burial 2 A Cremation 3 Removal from State 12/26/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory Signature of Funeral Ser 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ nor ten disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and deed betached for use as the burial-transit Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 1 Yes 2 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by brilla han To the Hospitel or Attending Physicien: The law requires within 24 hours efter death.

To the Funerel Director: After this certificate has been siç completely filled in by the funeral director, page 2 should It 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 **X** No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗆 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie りアナナ MD 900 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar Signature State 7 2012

DHMH 17 Rev 06-2011

Registrar

Records, P.O. Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Natalie Oxendine ′16/2°012 4:06p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 101 Center Place Apt 410 Dundalk 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 08/18/1947 Days Hours Director 214-44-8132 1 □ M 2 🛣 F 65 MD Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "natural", or items 23a or 28a-f ah. The Medical Examiner must be notified at Director Baltimore Dundalk MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Center Place Apt 410 21222 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Ś 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mantal Hyglane. Item 27 is marked other then other traumetic event, the Manuel other traumetic event, the Manuel other traumetic event, the Manuel other traumetic event, the Manuel other traumetic event, the Manuel other traumetic event, the Manuel other traumetic event, the Manuel other traumetic event, the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other events and the Manuel other e Elementary/Secondary (0-12) College (1-4 or 5+) Auditor Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Naomi Coster t. Paga 1 and 2 should ba fill thent of Health and Mantal tant: If item 27 is marked of Roland Tracey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shane Dial Son 8235 Dundalk Ave Dundalk MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State 12/20/12 Glen Burnie MD Atlantic Crem 4 ☐ Donation 5 ☐ Other (Specify) Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licens 22. Name and Address of Facility nom ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Phyaician: Tha law raquiras thet the daeth cartificate be exacuted within 24 hours eftar death.

To the Funeral Director: Aftar this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transif that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes Yes of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending thin 24 hours efter death. 5 Pending Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2801 BALTIMORE TUN

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 22,2012 5:45a Howard Hubbard Pinder Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4010 Aragon Avenue Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-16-8697 90 Director 1 **X** M 2 □ F Jan. 12, 1922 Maryland th and Mental Hygiene. 27 is marked other than "nature!", or iteme 23e or 28a-f ehow treumetic event, the Medical Examiner must be natified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City 1 A Yes 2 No Maryland n/a 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 USA 4010 Aragon Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: black 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Business Man Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Addie Hubbard Howard Pinder .. Pege 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachel Pinder/wife 4010 Aragon Avenue, Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pege 1 a
Depertment of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metro Crematory, Inc. | 12/24/2012 Baltimore, Maryland of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road, Baltomre, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ emen disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ed by the ettending physician and detached for use as the burlal-transit or Attending Physician: he law requires that the death certificete be executed Cause (Dissase or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 [XNo 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 2 🔁 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatu e and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A 373 Balto. .tay alls 21211 ٥ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

12-09831

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nthony John Pozzuoli State of Maryland / Department of Health and Mental Hygiene Certificate of Death												
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year								
ledical Examii		Anthony John Pozzuoli 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December 25, 2012 07 12 1118								
		2207 Pelham Avenue	Baltimore	N/A								
Funeral Director	- 1	5. Social Security Number 216-86-9709 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hrs Months Days Hours Min	IForeign Mary land								
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits								
. ₫	٦	Maryland N/A Balts	imore	1 XX Yes 2 No								
with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number 2207 Pelham Avenue	10f. Zip Code 21213	10g. Citizen of What Country? USA								
215-0036 be filed within 72 hours after death with the Maryland mial Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto Yes 2 X No specify:									
72 hours afte n "natural"; al Examine	eted by	15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation (Give kind of ing most of working life. DO NOT use ret	work done 16b. Kind of Business/Industry								
MD 21215-0036 d 2 should be filed within 72 hours tith and Mental Hygiene. m 27 is marked other than "natur numatic event, the Medical Exam	0	12 4 17. Father's Name (First, Middle, Last) Louis Pozzuoli		e (First, Middle, Maiden Surname) Suhomlin								
12 = 6 - 1	To Be	19a. Informant's Name/Relationship (Type, Print)	failing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)								
		Larisa Pozzuoli / Mother 20a. Method of Disposition 20b. Place of D	2207 Pe1ham avenue	e Baltimore MD 21213 Date 120c. Location - City or Town, State								
Ore, ges l ar t of He : ff ite		1 Burial 2 Cremation 3 Removal from State St. And	or other place)	2/28/2012 Baltimore Maryland								
Baltimore, permit. Pages I an Department of Hee Important: If ite	Į	4 Donation 5 Other Specify: 21 Signature of Funeral Service ensee	22. Name and Address of Facility Leonard J. Ruck, 5305 Harford Roa	Inc.								
Physician	f	23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval Between Onset and								
	Death											
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
	Examiner	cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
), be executed sician and nurial - transit	a EX	d		2								
6 be exerging yesician burial -	edical	■ MENDED 23a, pt.II, 27 IF FEMALE: 23c. If yes, outcome of pregnancy	,per me,g935 1-3-1	23d. Date of delivery								
Box 68760, s death certificate bette attending physical for use as the bu	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3 Ectopic pregr Other (Specify)									
that the dended by the		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?								
s, P.O. ires that the signed by d be detac	ed by	Heroin and cocaine use		1 Yes 2 No 3 Probably 4 ✔ Unknown 24a. Was an 24b. Were autopsy findings available								
Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending physicompletely filled in by the funcral director, page 2 should be detached for use as the b	Completed			autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No								
ital Rec ician: The s certificate rector, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outp	26.Place of Death (Check atient 3 DOA Other,4 Nurs	k only one) sing Home 5 Residence 6 ✔ Other: Scene								
n of Vi ding Phys th. : After this e funeral di	ion: To	1 Yes 2 No	ne of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred								
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm (Specify)	, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
To the Hospital within 24 hours To the Funeral completely fille	nd due to the cause(s) and manner as stated. If at the time, date and place, and due to the cause(s)											
To the I within 2 To the I complet	Medical	one) 2 Medical Examiner; On the basis of examination and/or inversal and manner stated 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
		Carol Hallan	O.C.M.E.	December 26, 2012								
,Ø		30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900	W. Baltimore Street, Baltimore	e, MD 21223								
S	tate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	wed									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland				and M	ental Hy	giene	201	2	41	922
	-	-	Registrar 1. Decedent's Name (First, Middle, Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral Lateral	st)		Cer	tificate of <i>E</i>	<i>Death</i>		2. Date of De	Reg. No		<u>~</u>	3. Time	of Dooth
	Physicia Medio		ARNETTA MARY	YANNA PER	RY					DEC Date of Bell	1 7 Da	2 0	12	2:35	
	Examin		4a. Facility Name (if not institution, give				4b. City, Town, or		of Death			. County of D		2016	
``	Funeral		SOUTHERN MARYLANI 5. Social Security Number 6. S		(In yrs. last	birthday)	CLINT	If Under		8. Date of Birt	th	RINCE (or Foreign
	Director		3/3 10 3001	□ M 2 🖾 F	82	Yrs.	Months Days	Hours	Min.	Month, Da, Sept 19			Countr		
	show	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	lown or Loc	cation	11					10	d. Inside (City Limits
	Maryl 28a-f	Funeral Director	MD Prince (George's	Uppe	r Mar	1boro					1 ☐ Yes 2x No			es 2x No
	ith the	ralD	10e. Street and Number				10f. Zip Code	log.					Citizen of What Country?		
	ems ?	-une	5424 Old Crain I	12. Was Decedent Ev	2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5					Decify Yes or No. 14 Bace			- American Indian,		
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machoal Exemple must be notified at	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.	0	If	Yes, specify Cuba	n, Mexican	, Puèrto P	ićan, etc.)		Black, W Specify:	/hite, et		
2-0	2 hour	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wo								g 7	16b. K	ind of Busine			
121	ithin 7, ene. r than	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+))	life. DO	O NOT use retired)	dinig most	or wortain		Geor	rgetow	n Ho	nenit	· a 1
של	filed w al Hygi d other	Be	17. Father's Name (First, Middle, Last)	<u>Z</u> y13		Dicc	ary	18. Mothe	er's Name	(First, Middle,			111	Jopie	.ar
ylaı	should be file h and Mental 7 is marked of traumatic eve	၉	Tull Perry					Rut	h Pei	ry					
Mar	2 shouth and the and the traum		19a. Informant's Name/Relationship (1	,	- 1		g Address (Street a						•	ode)	
ē,	1 and if Heal item 2		Rena Perry - Niec 20a. Method of Disposition		20b. Plac	e of Dispos	Florin Was	1		Maribo	20c. Location - City			vn, State	
<u>iii</u>			1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				natory or other plac 1 - Cemeter		L2 - 27	-2012	Sui	tland,	MD)	
21. Signature Fun al Service Licensee Marshall—March Funer										al Hom Suitlan	ne of	Mary:	 1and 46	i	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final													ate etween
-1	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a outher	esch	lera	ticler	die	VAS	Rulas	De.	Mase		Onset and	
	Examiner		resulting in deathy	Due to (or as a c	consequen		ilate							1.	/
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	consequen		race	0~					12	n Con	0-1
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. S/Ro Due to (or as a c	ke	ce of:							in	kno	D-~~
0	icate be executed physician and s the bunal-transit	edical E	resulting in deathy Last	I d	consequen	oe oij.									
8760	ifficate ng phy as the	Medi	IF FEMALE:	100											
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Difector After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	☐ Fetal d	eath 3 🗌	Ectopic pregnanc Other (specify)	у			1	23d. Date of Month		y Day	Year
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ds, F	quires the	ted by	myoCard	Inf	orct	in						□ No 3□			
3eco	sician: The law re certificate has bu lirector, page 2 sh	omple	- prevan	nca						24a. Was autop perfo 1 \sum Yes	rmed?	death	to com	sy findings pletion of	available cause of
酉	nding Physiclan: T tth. : After this certifica e funeral director, p	Be	25. Was case referred to medical examiner?				26. Pla	ace of Deat	h (Check		2 E NO		res z	LE INO	
Ž	Physi this c	유	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatien 28a. Date of injury		l/Outpatien		4 ∟ Nu		ne 5 🗆 Resid			ecify)		
o uo	r Attending ter death, rector: After by the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	(Month, Day, Y	Year)	injury	28c. Injury work' M 1 🗆	Yes 2 🗆		3d. Describe h	ow injury	y occurred			
Divis	tal or Atres after of all Direct ed in by		4 Homicide determined	28e. Place of Injury building, etc. (- At home (Specify)	e, farm, stre	et, factory, office		2	8f. Location (S City or Tow	street and n, State)	d Number or .	Rural F	loute Num	nber,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	(Check 2 ⊔ Medical Exam	sician: To the best of miner: On the basis of exa se Practitioner: To the b	mination ar	nd/or investi	gation, in my opinio	 n. death occ 	curred at t	he time, date a	nd place	and due to the	ne caus	se(s) and m	anner stated.
	with To the Control		29b. Signature and title of Certifier	Men.			29c. License		/		29d. Dat	te signed (Mo	nth, Da	ay, Year)	
			30. Name and address of person who	Completed source of the	th /ltam 00	On) (Time - D	960	157		Y	Le C	ems	272	17/	2012
\			9/35 Disc	two Rd	S	2-3	Bis di	Non	· ~	n 20	73	5			
	Stat Registra		31. Date filed (Month, Way, Year)		Signature	far	R								
				-		7 -									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20, 2012 11:20 AM Lucille Elaine Pellicane Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 20931 Lochaven Court Gaithersburg Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Hours Director 079-34-0259 1 □ M 2 K F 1943 New York Mar 31, 69 permit. Paga 1 and 2 should ba filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Macheal Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20931 Lochaven Court 20882 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Caucasian 3 🛛 Widowed 4 🗌 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Adele Frances Cording C. Meo<u>la</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Virginia R. Murphy</u> / Sister 20931 Lochaven Ct. Gaithersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 12/22/2012 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Sign sure of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that tha death certificate be axecuted within 24 hours aftar death.

To the Funeral Director: Aftar this certificata has been signed by the attending physician and completely filled in by the funaral director, paga 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 4 Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XResidence 6 Other (Specify) ဥ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D47964 December 21, 2012

State

Registrar
DHMH 17 Rev 06-2011

John L.

31. Date filed (Month, Day, Year)

3800 Reservoir Rd. NW Washington, DC 20007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marshall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 22 Physician/ 2012 John Puciloski December 6:36 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Laurel Regional Hospital</u> Laurel Prince George's **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min Hours 285-22-8257 Director 1**X** M 2 □ F 83 06/23/1929 PA ms 23a or 28a-f shov must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6032 Jerrys Drive 21044 United States "natural", or items; edical Examiner mu death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes f Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2X No Specify. 3 Midowed 4 □ Divorced Completed Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (US Navy) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Anthony Pucilowsky Susan Hudock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Joseph A. Puciloski - son 6034 Jerrys Drive Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Columbia Mem. Gardens 12/28/2012 4 Donation 5 Nother (Specif Entombment Clarksville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Thomas Manita 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transif Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death bed f a 🗌 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has perform Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending of Funeral Director: Aft e Funeral Director: Aft Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Signature and title of certifie

124

Registrar

DHMH 17 Rev 06-2011

State

Dr.

7300 Van Dusen Road Laurel, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pria Kuppusamy

D0072084

Perember, 22,2012

20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10f, 19b, per fh, g934 12-27-12 sm. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 24 201 DORIS PRESS December BERNICE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE COURTLAND GARDENS PIKESVILLE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🕅 F 215-22-2686 87 10/11/1925 MD Director Usual Residence of Decedent 10d. Inside City Limits la or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10b. County 1X TYes 2 □ No Directo BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a Examiner must b 21204 **21202** USA 1101 ST. PAUL STREET, APT. 1504 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married er than "natural", or the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 HOMEMAKER OWN HOME 12 should be filed what and Mental Hygie. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Irnportant: If item 27 is marked any injury or other traumatic ev MOSKOWITZ PRESS FREDA HERMAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1101 ST. PAUL ST., APT. 1504, BALTIMORE, LEONARD PRESS/BROTHER MD20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 Burial 2 □ Cremation 3 □ Removal from State ANSHÉ EMUNAH AITZ CHAIM CEMETERY 12/26/2012 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signeture of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ecause on each line. Immediate Cause (Final **Physician** o months /Medical resulting in death) Due to (as a consequence of): Examiner ular Q Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4⊡Pregnant at time of death 5 Other (specify) ed by the a Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4MNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2**7** No ٩ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division or this within 24 hours arrer death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification: (Month, Day Year) Injury Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mCRAP 7920 Scotts Level Rd Baltimore Maragret briona 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2012 Registrar

✓ DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 25. 2012 11:48P.M William Huestis Robbins December Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore County Towson Gilchrist Hospice Center 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 89 144-16-7682 June 10,1923 Catonsville, MD 1 🛣 M 2 🗆 F Director Vrs Usual Residence of Dec 10d. Inside City Limits 10c. City, Town or Location 10h County 1 Yes 2 No Parkville 28a-f Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 238 21234 3017 Summit Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? IT C. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No No.S.

If Yes, Give No.Y.

Year or Dates 1.7 Yes 1 Never Married 2 X Married Š filed within 72 hours efter Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates.W_W_I 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Gas Hygiene. College (1-4 or 5+) N/A Flementary/Secondary (0-12) and Electric Overhead Construction Designer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 end 2 should be file Department of Heelth end Mentel Himportant: If item 27 is merked o eny injuy or other traumetic eve ans injuy or other traumetic eve Helen Lowery Carl Welsh Robbins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21234 Parkville, Maryland 3017 Summit Ave. Mrs. Joy S. Robbins / Wife 20c. Location - City or Town, State
Harford County 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Coremation 3 Removal from State
1 Donation 5 Other (Specify)

Signature of Funeral Service Licensee Ferrey L. Cair, Sr. CFSP 22, Name and Address of Friday Forest Hill, Maryland Dec. 28, 2012 ²² Name and Address of Facility Procedure Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 23a. 1 of 1. sner/ he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List billy one cause on each line. **Approximate** Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ aucreatio Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Filter Underlying Examiner Due to (or as a consequence of): ior: After this certificate hes been signed by the attending physicien and the funerel director, page 2 should be detached for use es the burlal-trensit Cause (Disease or injury or Attending Physicien: The law requires thet the death certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Ct. IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes ဂ္ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Division 24 hours after deeth.

Funerei Director: Af ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Fune completely fi 29a. Certifie 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Sign re and title of certi JBO F1787 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sugheen, 6701 N. Charles

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Thomas Lee Riley December 5:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 909 Oakleigh Beach Road Dundalk Social Security Number 6. Sex 1 XM 2 □ F 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Feb 8, 1960 213-86-7454 OkTahoma **Director** 52 Yrs Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 909 Oakleigh Beach Road 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 ☐ Yes 2 X No If Yes, Give 1X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Painter Painting / Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Leon Riley Mary Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Leon Riley, Father item 27 i 1707 Eastgate Drive Apt.305 Salisbury, MD 21804 Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o' ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/24/12 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor Name and Address of Fac emation Soc. 9 Frederick ociëty Of ck Road Maryland Baltimore Inc. Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 9 GUN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury for use as the burial-trans the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown to the Funeral Director. After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Hospital: Other: 2 🗆 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 501Certificate: 1 Natural 5 Pending Accident Investigation 24/2012 0550A unsho Director: 3 Suicide 6 Could not be City or Town, State) 9090 GK-9GM (Secchol) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Home within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a

Lrimp

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Emerson 2012 930 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) 219-28-8049 Director 1 🕅 M 2 🗆 F 82 Oct. 7, 1930 MD Usual Residence of Deceden ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Howard West Friendship 10e. Street and Number 10g. Citizen of What Country? Funeral 12494 Barnard Way 21794 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black. White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give 10 \$ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1951-53 White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Utility General Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Gilman Rich other traumatic Catherine Courtney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau once. Mrs. Dorothy Miles Rich (Wife) 12494 Barnard Way West Friendship, MD 21794 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 1 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation ! 12/22/2012 | Sykesville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications tital caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician 513 disease or condition resulting in death) Medical Due to (or is a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to kr as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No director. B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 🛂 No 잍 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA s after death.

I Director: After this ed in by the funeral di 28a. Date of injury (Month, Day, 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tyes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours aft

To the Funeral Dis

completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the F only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) Dec 21; 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) der Lane Columbia, MD 21044 State Registrar

12-09456 John Reed Ross Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 41929

		1- For State Certificate of Death Reg. No.														
Physici	an/	1. Decedent's Name (Fir								1	2. Date of Dea Month	Day	Yea	r	3. Time of	
edical Exami	ner	John Ree					L				Decembe	er 12, 2	2012		1326 I	nrs
		4a. Facility Name (if not 948 Ridge Road	d #2					v. City, Town, Westmins	ter			C	c. County o			
Funeral Director		5. Social Security Number 203-30-59	044	ex M 2∏F	7. Age (In yr		nday) Yrs.	If Under 1 Your Months Da	ays Hou	der 24Hrs.	8. Date of Bi	,		Foreign	1	te or ID
nd show any occ.	or		County arroll			ity, Town										City Limits
the Maryla n nr 28a-f iffied at o	Director	10e. Street and Number 948 Ridge		Apt	2			10f. Zip Code 2115				10g. Citizen of What Country? USA				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	2 Married	Armed F	2 N		If Yes	Decedent of Is, specify Cub	an, Mexica	n, Puerto F		0-	14. Race White Specify:	e, etc.	an Indian,	Black,
MD 21215-0036 and 2 should be filed within 72 hours after lealth and Mental Hygiene. tem 27 is marked other than "natural", traumatic event, the Medical Examiner	Completed t	15. Decedent's Educati Elementary/Secondar		College (* 1 y r		- (during mos	s Usual Occup st of working li : Meta	fe. DO NO	T use retire	ed)		Kind of Bus Fabr		ndustry tion	
5-00 ed with lygiene other	Com	17. Father's Name (First	, Middle, Last)			1	-		18.Mother's Name (First, Middle, Maiden S					Surname)		
215 be fill antal H irked	Be	Robert E	_								inia					oss
O 21 should nd Me is ma	은	19a. Informant's Name/R Judy Lee		ype, Print) Sist	or			Address (Str								
and 2 sealth a cm 27		20a. Method of Dispositi		DISC				on (Name of		Tive	Date	_			Town, State	
timore		1 Burial 2 X Cremation 3 Removal from State cre						c Cre			20/12					
Bal perm Depa Impu	21.8 fignature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Cres Thomas Allen PA 7090 Ridge Ro															
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line.									ock, or hea	art		ate Interval Onset and				
/Medical Examiner		Immediate Cause (Final or condition resulting in	disease a.	Atheroscle			ar Dise	ase								eath
	-e	Sequentially list condition if any, leading to immediate		Due to (or as a	consequenc	e of):										
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
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760, cate be exe physician a	edical	UNPENDED		AMENDED												
Division of Vital Records, P.O. Box 68760, To the Hospital or entificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	- 5	IF FEMALE: 23b. Was decedent pregress 12 months? 1 Yes 2 No 9		1 Live t	ant at time of	2		ll death 3 er (Specify)	Ector	ic pregnan	су	23	d. Date of o		ay	Year
O. Be nat the deed by the stached for		Part II. Other significan		9 Oliki		ot resulting	in the un	derlying cause	given in f	Part I.	23e. Did 1	obacco	use contril	bute to t	he cause of	f death?
S, P.C.	ed by					_									ably 4	
of Vital Records, as Physician: The law require the this certificate has been sineral director, page 2 should be	Completed									_			p d		ompletion o	
tal Rec cian: The certificate ector, page	Be	25. Was case referred to examiner?	h-	lospital: 4	1	7			Other	(Check or		1		4		
Physic Physic er this eral dir	2	1 ✓ Yes 2 2 27. Manner of Death	No	28a. Date	of Injury		tpatient		jury at Wo		Home 5 28d. Describe		ence 6		Scene	_
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Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification	2 Accident 3 Suicide 6 4 Homicide	Investigati Could not determine	be 28e. Plac		t home, fa	rm, street	, factory, office	building,	etc. 2	28f. Location or Town,		and Numbe	r or Rur	al Route Ni	umber, City
To the Hos within 24 h To the Fun completely	Medical (CHECK OTHY	ifying Physici lical Examiner		of examinatio	_										
5 ± ± 5 8	Me	29b. Signature and title	of certifier	And marriers	stated.		-		nse numbe	r			-		th, Day, Yea	ar)
of m		30. Name and address of	of person who	Completed cau	se of death (II	tem 23a)		0.0	C.M.E.			Dec	cember	13, 20	12	
1,0		Melissa Brasse	II, MD A	ssistant Me	dical Exar	niner		Baltimore	Street,	Baltimor	e, MD 212	23				_
St Regis	tate	31. Date filed (Month, Da		32. R	egistrar's Sign	Mar	Karl									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Theresia Robinson December 2012 10:15 P^M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 28 Amanda Dr. Smithsburg Washington 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Sept 9, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 570-42-0077 1929 1 □ M 2x F 83 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Washington Smithsburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 28 Amanda Dr. 21783 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 🙀 No Specify. white 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk post office 17. Father's Name (First, Middle, Last) $\,\, { m unk} \,$ 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Robinson - husband 28 Amanda Dr; Smithsburg, MD 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board re of Firmural Service Ronald Made Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death disease or condition 20.00 resulting in death) Due to (or as a consequence of): Sequentially list conditions Dus to (or as a consequence of): arry, leading to immediate

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

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should be filed with and Mental Hygien 7 is marked other th

permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev

Director

Funeral

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Completed

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within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine and -trar Physician/Medical signed by the Medical Certificate: To Be Completed by page 2 funeral within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (s			23d. Date of delivery Month Day Year							
Part II. Other significant conditions con	ntributing to death but not resulting in the underlying	g cause given in Part I.		use contribute to the cause of death?							
			24a. Was an autopsy performed?								
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 Yes 2 Poo	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ [DOA Other: 4 \(\sum \) Nursing Hor	ne 5 🛛 Residence	6 ☐ Other (Specify)							
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury 28b. Time of injury M		8d. Describe how inju								
4 Homicide determined	28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
(Check 2 Medical Examine	cian: To the best of my knowledge, death occurred er: On the basis of examination and/or investigation, in Practitioner: To the best of my knowledge, death oc	n my opinion, death occurred at t	the time, date and place	e, and due to the cause(s) and manner stated.							

29c, License number

007-2463

29d. Date signed (Month, Day, Year)

Registrar

State

29b. Signature and title of certifie

31. Date filed (Month

ge of death (Item 23a) (Type, Print)

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(su ham Oit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 220 1350 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospice of the Chesapeake Harwood Anne Arundel Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year) Director 578-70-6574 1 M 2 | F 59 Wash. DC Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director or 28a-f MD. P.G. XYes 2 No Capitol Hgts. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 808 Booker Drive 20743 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 \(\text{No. 6 / 71} \) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or Š 1 Never Married Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates. 1 Yes XXNo Specify. Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Smithsonian Mail Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Ross Mary Powers other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delilah Ross/Wife 808 Booker Drive, Capitol Hgts. Md 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 13C18Burial 2 Cremation 3 Removal from State injury or Glenwood Cemetery Washington, DC 1/2/13 4 Dogation 5 Other (Specify) 22. Name and Address of Facility
Hackett's Funeral Chapel
R14 IJpshur Street, NW D f Funeral Service 21. Signatu any 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRAN Physician/ WER NCER disease or condition TYER Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 2 🔼 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21401 MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Registrar DHMH 17 Rev 1/200 Amanda

31. Date filed (Month, Day, NFC 2 7

Kitch

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malone

Year)

1509

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 Ridd1e 2012 5:54P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Director 404-46-2638 1 M 2 X F 82 01/30/1930 Japan J. Hygiane. other then "neture!", or kerns 23e or 28e-f show rent, I're Medical Examinar must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location be fliad within 72 hours aftar death with the Maryland Director 1 Yes 2 No MD Glen Burnie Anne Arundel 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 896 Gordon Drive 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 2 1 Never Married 2 X Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Japanese 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Ft. Meade Post Exchange lith and Mental Hygla 27 is marked other r treumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ unknown unknown 1 and 2 should by Haalth and Me Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 Mr. Don O. Riddle / Husband 896 Gordon Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1 Dapartment of Important: If it eny injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 12/26/2012 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD MO1479 000 Singleton Funeral & Cremation Services, PA DMC 23a. Part 1. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Examine o cartificata has baen signed by tha attanding physician and ilractor, paga 2 should ba datached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of VItal Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 M No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: Within 24 hours after death.

To the Funeral Director: After this cartific complataly filled in by the funaral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier (Check

only one)

3 🖂

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) DEC 2 7 2012

2480 LL

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

enellyn

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

AVE, FORT MEADE, MO 20755

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:40A M Bruce James Ray 12 2015 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sales bury Coastal Hospice at the Lake W. comico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Ohio **Funeral** 8. Date of Birth (Month, Day, Year) 05/08/1943 Days Hours Min. Director 1 M 2 □ F 217-42-2793 69 28a-f show 10a. State 10b. County the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Cumberland Windham 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with PO Box 1785 04062 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: us should be filed where all and Mental Hygies and Mental Hygies and a marked other then "natural" and, the Medical Event, the Medical Event, the Medical Event, the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Event and the Medical Eve "naturai", 3 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Architecture</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Homer Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Ray / Brother 411 Dudley Avenue, Pocomoke City, MD 21851 ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State important: If eny injury or once, 4 Donation 5 Other (Specify) Chesapeake Crematory 12/25/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Mach Physician/ Sqr COU Conconena disease or condition Medical resulting in death) Due to (dras a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, Completed To the Hospitel or Attending Physiclen: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes No 1 ☐ Yes 🛛 No Hospitel or Attending Physicien: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Bc. Injury at Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 63199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHORE DR., SALISBURY, HD 21804. 910 YOGESH VOHRA 31, Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 7 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend 1tem 26 per doc g934 12-27-12 vt

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19 Physician/ Month 2012 Lillian 4:15 A Medical May Runkles December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4802 Diane Ave. Mt. Airy Carroll 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours **Director** 218-74-3142 1 M 2 XF 94 Aug. 18,1918 Maryland Usual Residence of Deceden item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4802 Diane Ave. 21771 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 V Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 6 own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Simmont Lillian May Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pege 1 and 2 sh ment of Health a tant: If item 27 is David L. Runkles/ son 43451 Evans Pond Rd. Leesburg, VA 20176 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Removal from State permit. Pege Department Important: It eny injury or 4 ☐ Donation 5 ☐ Other (Specify) Prospect Cemetery 12/21/2012 nr. Mt. Airy, MD 21. Signature of Fuheral Service Licens 22. Name and Address of Facility Hartzler Funeral Home, P.A. <u>11802 Liberty Rd.</u> Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) 420n Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): απending physician and for use as the burlal-transit Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: A Nursing Home 5 K Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Ecertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R069707 2012 and address of person who completed cause of death (Item 23a) (Type, Print) JACQUELINE HEARN CRNP 688C POOLE ROAD IDESTMINSTER MD 21157 31. Date filed (MoAtin Day, Year) State Registrar

DHMH 17 Rev 06-2011

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 23 2012 Violet Elizabeth Rosato Dec 4:30A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Emeritus Senior Living Carroll Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 201-09-3122 Director 93 Yrs 06/16/1919 Usual Residence of Deceden PA or then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Washington Road 21157 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Specify.White 3 ₩idowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be filed nt of Health and Mental H: If item 27 is marked ott Edgar Lippencott Violet Traband 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Rosato-son 1250 West River, Rd, Shady Side, Md. 20764 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or otf Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arlington Cem. 12/27/12 Drexel Hill, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFletcher Funeral & Cremation 254 E. Main St., Westminster, MD 21157 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line.

Immediate use (Final Approximate Interval Between Onset and Death Physician/ Chronic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Lension Sequentially list conditions. Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-transit or Attending Physiclan: The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed | 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

Of the Funeral Director, After this certificate has been sig completely filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spe 1 Tes 2 No Alsst Living |2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 2 4 9 3 7												
		-	Registrar 1. Decedent's Name (First, Middle)	e, Last)				Jeain	2. Date of I				of Death
	Physicia Medic				RUDE CATHI	ERINE RE	IOADES		Decemi Decemi	er 19	, 2012 Year	4:14	₽ м
	Examin	er	4a. Facility Name (if not institution Chesapeake Wood		ber)		4b. City, Town, or Cambri		Death	40	Dorcheste	r	
	Funeral Director		5. Social Security Number 215-05-1685 Usual Residence of Decedent	6. Sex	7. Age (In yrs. Ia 97	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month,	Birth Day, Year) 22, 19	Cou	Birthplace (State or Foreign Country) Maryland	
	ıryland a-f show ied at	Director	10a. State 10b. County Maryland Dorche		10c. City	, Town or Lo		t New M	arket			10d. Inside	City Limits
	ith the Ma 3a or 28a it be notif		10e. Street and Number 3540 Oce	an Gateway			10f. Zip Code 216	31		10g. Ci	itizen of What Co		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☒ Widowed 4 □ Divorced	rried Armed For	2 🗓 No e	The Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specification of Programme 1) 15. Was Decedent of Hispanic Origin? (Specification of Programme 1) 16. Was Decedent of Hispanic Origin? (Specification of Programme 1) 17. Was Decedent of Hispanic Origin? (Specification of Programme 1) 18. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Hispanic Origin? (Specification of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was Decedent of Programme 1) 19. Was					14. Race - Amer Black, White		
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Maryland	12 should alth and M 27 is mar r traumati		19a. Informant's Name/Relations Mr. James E. Rhoad		(Son)				or Rural Route Num ast New Mar				
Baltimore,	age 1 and ent of Hez nt: If item ry or othe		20a. Method of Disposition 1 🕱 Burial 2 🗆 Cremation 4 🗆 Donation 5 🗀 Other (StateC6	emetery, cren	sition (Name of natory or other plac Cemetery		Date c 24, 2012	1	ocation - City or		and
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Divisi	tal or Atters after de al Directo		4 Homicide determ	buildir	ng, etc. (Specify))	eet, factory, office		City or T	own, State			nber,
	the Hospi nin 24 hou the Funer npletely fil	Medical	(Check 2 Medical I only one) 3 Certifying	Physician: To the be Examiner: On the bas Nurse Practitioner	is of examination	and/or invest	igation, in my opinio death occurred at t	on, death occ he time, date	urred at the time, dat	e and place	e, and due to the c	ause(s) and m	nanner stated.
0	N Mit		29b. Signature and title of certifie	mul	~		D2	876	9 tyhwa !	29d. Da	ate signed (Month	, Day, Year) 12	
			30. Name and address of person Nimolar 31. Date filed (Month, Day, Year)	who completed caus	e of death (Item	12	og Coas	ted A	tyhwa !	Feno	viete Iz	1, De	19944
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mallie Shaw 20^{Year} 2:05 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilcrest Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 216-24-4177 **Director** 1**X**] M 2 □ F 81 Yrs. 09/12/1931 Carolina Usual Residence of Deceder parmit. Pega 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show eny Injury or other traumatic event, the Medical Evandar must be availed at 10c. City, Town or Location 10d. Inside City Limits rector Baltimore N/A MD 1 ¥ Yes 2 ☐ No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5510 Daywalt Ave. 21206 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Terminal Elementary/Secondary (0-12) College (1-4 or 5+) Longshoreman Dundalk Marine 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Samuel H. Shaw Hattie Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary F. Shaw 208 E. Lanvale St. Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/31/12 Baltimore, MD 4 Donation 5 Other (Specify) Arbutus 21. Signature of Funeral Service Lice 22 Jansan Addres For Facility own, Jr. Funeral Home PA ▶ 2140 N. Fulton Ave. Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 2 MStore CONTCES disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): inding physician and use as tha buriel-trensit Exami Attending Physician: The law raquiras that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 attanding p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) is certificata has bean signad by the arepsilon diractor, paga 2 should be detached i ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 N prior to completion of cause of death? death? 2 🗆 No 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 KNO 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phy within 24 hours aftar daath.

To the Funeral Director: After this complataly filled in by tha funaral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29b. Sia December 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UHARVES N

Registrar DHMH 17 Rev 06-2011

State

AMON

31. Date filed (Month, Day, Year)

6701

W

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert F. Shipferling 2012 December 6:20 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Brightview Avondell Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 219-07-1440 Maryland 93 Director 1 M 2 □ F Vovember 18, 1919 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 ☐ Yes 2XXXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 United States 128 W. Ring Factory Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Distribution Center 12 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Kammer Royal Shipferling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Conklin (Daughter) 1705 A. Singer Road, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Parkwood Cemetery 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State December 28, 2012 Parkville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fuheral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 23a. Part 1. Enter the insease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he will fellure. Let only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Blow Physician/ dder came disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Assisted မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No r death 2 Accident
3 Suicide the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Funeral Medica within 24 hound to the second 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D32228 December 26, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. Mapha R-101/20 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 06-2011

Registrar

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Sue A. Schantz 2:40 A. M 23,2012 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brightview Nursing Center Baltimore County Towson 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 218-26-2212 82 **Director** Feb. 09, 1930 Jessup Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director N/A 1X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be injury or other traumatic event, the Medical Examiner Funeral 21206 United States 5711 Seymour Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes Give Completed 3 X Widowed 4 □ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 02 Clerical Office should be filed with and Mental Hygien is marked other ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E.Alan Armstrong Marie Heaps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret S. Miller / Daughter 5711 Seymour Ave. Baltimore, Maryland 21206 f Health a tem 27 i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Harford County permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20a. Method of Disposition

| 20b. Place of Disposition (Name of cemetery, cremation of Disposition (Name of cemetery, cremation of Disposition (Name of cemetery, cremation of Disposition (Name of cemetery, cremation of Disposition (Name of cemetery, cremation of Disposition (Name of Cemetery, cremation of Disposition (Name of Cemetery, cremation (Name of Cemetery, Cemetery, Cremation (Name of Cemetery, Cemetery, Cremation (Name of Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemetery, Cemet Dec.27,2012Forest Hill, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. mmediate Cause (Final Onset and Death STAGE DEMENTIA Pnysician/ disease or condition Know A Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last and trar Due to (or as a consequence of): nding physician use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ atter for u in the past 12 menths?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? DEBILITY. 24a Was an page 2 s performed' certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be ASSISTED IVINE examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) Hospital: 1 ☐ Yes 2 ☐No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work?
1 Yes 2 No n 24 hours after death.

Reference of Funeral Director: A pleted filled in by the funeral pleted filled in by the funeral pleted filled in by the funeral pleted filled in by the funeral pleted filled in by the funeral pleted filled in by the funeral pleted filled in by the funeral pleted filled in by the funeral pleted filled in by the funeral pleted filled in by the funeral pleted filled fi 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar _____ ✓ DHMH 17 Rev 7/2009

within 2.

To the F
complet

29b. Signature and title of certific

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

57

Registrar's Signature

CHARLES

STE 4105

barket

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

1072544

29d. Date signed (Month, Day, Year) 12/24/2012

		A	Please MEND PI LINE A-B, 1 _ State	Type or Print in 25, 27, 28A State of Maryla				Ire All Copie /12 TRT ind Mental Hy	es Are /giene	Legible.	41941	
	7		Registrar 1. Decedent's Name (First, Middle, La	ct)	C	ertificate (of Death		Reg. No.			
	Physicia		Pamela L. Sling					2. Date of De Month Decemb		2012	3. Time of Death 7:00 A M	
	Medic Examin		4a. Facility Name (if not institution, give 616 Brightwood	e street and number)			vn, or Location of		4c. County of Death Baltimore			
	Funeral Director		Social Security Number 6. S		s. last birthday	/) If Under 1 Months D		8. Date of Bi Min. (Month, Di 10/17/	rth	9. Birth	place (State or Foreign	
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	vith the Ma 23a or 28a st be notif	eral Dire	10e. Street and Number 616 Brightwood Cl		TOTICE VI	10f. Zip Co 210			109. Citiz Un i	tizen of What Country?		
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	U.S. 13	If Yes, specify	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)		4. Race - Amer Black, White Specify: Wh	, etc.	
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Maryland 2	d be filed w Aental Hygi Irked other Itic event, t	மெ	17. Father's Name (First, Middle, Last) Ivor Lloyd				I	r's Name <i>(First, Middle</i> Lian Anita	, Maiden S	urname)		
, Mary	nd 2 should lealth and N m 27 is ma her trauma		19a. Informant's Name/Relationship (1 Deirore S. Purdy	/ daughter	616	Brightw	ood Club	or Rural Route Numb Drive Lu				
Baltimore,	t. Page tment c tant: If jury or		20a. Method of Disposition 1	Removal from State	cemetery, c	position (Name of the serv. C	orp.	Date 12/10/2012	Tows	cation - City or T	cyland	
Ba	permit Depar Impor any in		21. Signature of Euneral Bervice Licen	Dall				Ruck Towson, N				
	nysician/ Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	to +1			ardiac or respiratory a		FRACTU	Approximate Interval Between Onset and Death	
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09	n certificate be executed ending physician and r use as the burial-transit	I— I	that initiated events resulting in death) Last	Due to (or as a conse	equence of):		CER	TIFICATION APPROVED P	A MEDICAL	EXVIII		
. Box 68760	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici rai director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live Birth 2 F 4 Pregnant at time of	etal death 3	B	gnancy	1		23d. Date of deli Month	very Day Year	
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<u>ital</u>	ysician: The iis certificate director, pag	Be	25. Was case referred to medical examiner? 1 X Yes 2 X No.	Hospital:		-4	Other	(Check only one)		181		
of V	g Physer this eral d	e: 1	27. Manner of Death	1 ☐ Inpatient 2 28a. Date of injury	28b. Time	of 28c.	I 4 LINur Injuryat	sing Home 5 Res 28d. Describe			(y)	
<u>-</u> 0	r Attending F er death. rector: Affer t by the funer.	icat	*1 Natural 5 Pending 2 Accident Investigation		2 2030		work? 1 ☐ Yes 2X☐	N∘ SUBJEC	T FEL	L		
Divisi	5 분 중 등	al Certificate:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec AT HOME	home, farm, cify)	street, factory, o		28f. Location (City or To DR, LUT	(Street and wn, State) 'EHRVI	T FELL Street and Number or Rural Route Number, State) 616 BRIGHTWOOD CLUF EHRVILLE, MD		
	Hospital of 24 hours a Funeral C	Medical	(Check 2 Medical Exam	rsician: To the best of my kno niner: On the basis of examina rse Practitioner: To the best or	tion and/or inv	estigation, in my	opinion, death occ	curred at the time, date	and place,	and due to the c	ause(s) and manner stated.	
	To the within To the complete	2	29b. Signature and title of certifier		. my knowieu		cense number	o piace, and due to		s) and manner as e signed (Month		
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1	10)		30. Name and address of person who Alexa F Far	aday Mo	4=		1. Char	er # 410) 6	Balt	MO 21204	
	Star Registra		31. Date filed (Month, Day, Year) NFC 2 7 201	2. Registrar's Sig	nature	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dec Day 14 4:20 PM Clarence Robert Stevens Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 27, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Director Maryland 216-42-0249 1 x M 2 □ F 66 Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TyrYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1213 Union Ave. 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. <u>۾</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/IndustryUn (Specify only highest grade completed) Elementary/Secondary (0-12) College (1,4 or 5+) UNK laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clarence Stevens Rosina DeMarco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3004 Steamer Run; Cambridge, MD 21613 Margaret Wallace - cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state 22. Name and Address of Facility State Anatomy Foard 21. Sign ture of Funeral Service License Bout & week 655 W. Baltimore St; Baltimore, MD 21201 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery lor 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Month Year 1 Yes 2 No Pregnant at time of death the 9 Unknown ğ signed t Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٩ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 0 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHLOW Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death STEINRUCKEN Physician/ NNEIH 0441 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Mandrin House Anne Arundel Harwood 9. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** March 24, 1950 Days Hours Min. Director 217.54.0572 1X□ M 2 □ F 62 -1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8560 KimMarie Court. 21122 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White If Yes, Give Specify: 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) US Postal Service 12 Mail Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kenneth L. Steinrucken Sr. Ellen Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Steinrucken- Brother 4550 Whetstone Ct. Hampstead, MD 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Atlantic Crematory 12/23/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) of Catonsville, Inc. 1830 Edmondson Ave. 21. Signature of Funeral Service Licenses MOIOSD Catonsville MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe 999897V+7984th S Immediate Cause (Final ROS TA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed safter death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 1 Yes 2 9 Unknown 2 No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4- Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: CII 횬 1 🗌 Yes 2 No ARE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title an who confideted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

		-	For State		epartment of Health and	d Mental Hygier	2012	41944			
			Registrar 1. Deedent's Name (First, Middle, La		Certificate of Death	Reg. I	No.	3. Time of Death			
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	laryland 3a-f shov iffied at	Director	10a. State 10b. County	10c. City, Town	or Location Himore		:	10d. Inside City Limits 1 Seres 2 □ No			
	with the M 23a or 28 ast be not	Funeral Dir	10e. Street and Number Morle	1	10f. Zip Code 2/229	10g.	Citizen of What Co	untry?			
9036	permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	(Specify Yes or No- uerto Rican, etc.)	14. Race - Amer Black, White Specity:				
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Baltimore,	Page 1 ar nent of Hi ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	Removal from State	Disposition (Name of), cremator for other place) What emetery 13	2/29/12 M	Location - City or	Town, State			
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\mathbb{R}^{d} \mathbb{R}^{d} \mathbb{R}^{d} \mathbb{R}^{d} Division of Vital Records,	The law requate has beer page 2 shou	Somplete	?		-	24a. Was an autopsy performed	prior to or death?	topsy findings available completion of cause of			
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∩ ∩ ∩	d ing Phys h. After this funeral dii	ate: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of injury (Month, Day, Year) 28b. T	ime of 28c. Injury at work?	ng Home 5 Residence 28d. Describe how in		ify)			
hα ivisio	or Attendafter deat Director: In by the	Certificate:	2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e Place of Injury - At home for	M 1 Ves 2 No 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and						
√ 1 □	Hospital 24 hours Funeral I etely filled	Medical ((Check 2 Medical Example (Check 2 Medical Example)	ysician: To the best of my knowledge, on iner: On the basis of examination and/on	investigation, in my opinion, death occur	red at the time, date and pla	ace, and due to the	cause(s) and manner stated.			
	To the within To the comple	Σ	20h Signature and title of Artifier	aresh Bhandan,	29c. License number	29d.	Date signed (Month				
	100		. \	completed cause of death (Item 23a) (I	ype, Print) a for Avenue,	Baltimor	e,MD,	2122.0			
	Stat Registra		31. Date filed (Month, Day, Year) NFC 2 7 201	32. Registrar's Signature	ake						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death athleen Physician/ ecember Medical Facility Name (if not institution/give street and number) Examiner 4c. County of Death 0 None Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yr. last birthday) 9. Birthplace (State or Foreign Days Hours Country Director 288-14-7996 1 □ M 2**X**□ F 89 11/07/1923 Ohio 28a-f show ir than "naturel", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard 1 Yes 2 X No Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 8125 Yellow Pine Drive 21043 United States 12. Was Decedent Ever in U.S. Arroed Forces?
1 ⚠ Yes 2 ☐ No If Yes, Give WWW 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 XWidowed 4 ☐ Divorced WW II White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed end Mental H is marked ot Thomas O'Toole Rose Tomlinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health er Important: If Item 27 is any Injury or other trau 7211 Woodbine Road Woodbine, MD Regina Sokas - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 (Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🛛 Removal from State TBA 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. Arlington, VA any Inj once, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Some 12 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cashe on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery within 24 hours after death. **To the Funerel Director:** After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u in the past 12 months?

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9 Unknown 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? ☐ Yes 2 10 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License numbe 50025 suse of death (Item 23a) (Type, Print) 30. Name and address of pe rson who completed on ROS 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month :18(AM 17 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Min Months Hours Director 055-22-9794 1925 New York Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1 Yes 2XXNo Howard Ellicott City 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 9770 Hillsmere Road 21042 United States items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates be filed within 72 hours after ental Hygiene. 'ked other than "natural", or 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental H item 27 is marked of ဂ William Militscher Gertrude Van Gulick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Suydam, Daughter 9770 Hillsmere Road, Ellicott City, MD 21042 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cresthaven Memorial |12/29/2012 | Clifton, New Jersey Signature of Fureral Service Licensee T.Harman 22. Name and Address of Facility Harman Funeral Service, PA 250 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Plulmonomy Disto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year signed by the at d be detached fo g Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 🕒 death? certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No Nursing Home 5 Residence 6 Other (Specify) |요 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural iniury 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year 32. Registrar's Simature State 7 Registrar

ØHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death S. Stone Physician/ Allen pecember 21°, 2012 9:55 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAltimore Dundalk 3009 Sollers Point Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 214-26-3686
Usual Residence of Decedent 1 X M 2 □ F 82 Maryland lovember 2, 1930 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk Maryland Baltimore 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21222 USA 3009 Sollers Point Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Steel General Foreman 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Elizabeth Mehoke Dorrah P. Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Wife 3009 Sollers Point Road, Dundalk, Maryland JoAnn Stone 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD 28, 2012 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA 21. Signature of Funeral Service License Connective Fundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. MULMONS 21222 Part 1. Enter the disea e. / r complications that caused the disah. Do not enter shock, or heart failure. Not only one cause on each line. the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burlal-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 certificate 2 🗌 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 🗵 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only ene) 29b. Signature and title of certifier ne and address of person who completed cause of death (Item 23a) (Type, Print) 5200 FAS Julianne 6 -hea 31. Date filed (Month, Day, Year)
DEC 2 7 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Deanh 8 Dimone :20 Medical Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner BURNIE Washington Mac 6. Sex 7. Age (In vrs. last birthday Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours Min 09/08/1927 Director 85 214-22-5834 Usual Residence of Decedent 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie 1 Yes 2 No Anne Arundel MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 21061 U.S.A. 307 Gloucester Drive death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. P 1 Never Married 2 Married Completed by hours after 21215-0036 and 2 should be filled within 72 hours afti Health and Mental Hygiene. tem 27 is marked other than "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify 3 XWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Food Service 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Crossland L.L. McKeever 19a. Informant's Name/Relationship (Type, Print) daughten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Linthicum, Maryland 21090 Mrs. Theresa M. Graham / 5926 Linthicum Lane, injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 12/24/12 Glen Burnie, Maryland Haven Mem. Park 21. Signature of Funeral Service Licens Glen Burnie, MD 22. Name and Address of Facility 1 2nd Ave, SW any Singleton Funeral & Cremation Services, P.A. M01357 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ EY Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions Examine cause. Enter Underlying MEMNGIOMO Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P,O, Box 68760 the use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Dav Year Pregnant at time of death the be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed this certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Tyes ၉ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural Accident 5 Pending 2 🗌 No 24 hours after death. Funeral Director: A 1 Yes Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 To the I

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

iled (Month, Day,

7 2012

Registrar

death (Item 23a) (Type, Print).

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32. Registra

ss of person who completed cause of

29c. License number

29d. Date signed (Month, Day, Year)

20 2012

Deamber

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18.per INF, g836 2-15-13 sm State of Maryland / Department of Health and Mental Hygiene												
		•	State Registrar			Certificat			VICITAL 11y	Reg. No	6111	41949	
ı	Physicia Medic		1. Decedent's Name (First, Middle, Las Chan Faru	Shan					2. Date of De Month	eath Da	Year 2012	3. Time of Death 629 M	
(Examir		4a. Facility Name (if not institution, give	street and number)	J	4b. Gity	Town, or	Location of Death		4c	. County of Dea	ith	
	Funeral Director	į	Social Security Number 6. S		yrs. last birth	day) If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 01/27		25 g. Bi	rthplace (State or Foreign ountry) China	
	Aaryland 8a-f shov tified at	rector	MD 10a. State 10b. County Montgom		Silv	or Location ver Sp	ring	J	-			10d. Inside City Limits 1 Yes 2 No	
	h with the h ns 23e or 2 nust be no	Funeral Director	10e. Street and Number 3210 N. Leisur	e World Bl	.vd		906		,(1	-	tizen of What C	ountry?	
9800	permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f show with injury or other treumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	n U.S.	13. Was Dece If Yes, spe 1 Yes	cify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit Specify: AS	te, etc.	
215-(n 72 hou en "nat Medica	Completed	15. Decedent's E (Specify only highest grants) Elementary/Secondary (0-12)			Decedent's Usu Give kind of wo life. DO NOT us	rk done o	ation during most of wor	king	16b. Kind of Business/Industry			
121	Teacher										ducati	.on	
Purp									ne (First, Middle, J-Yang	Maiden	Surname)	Sung Shih	
Baltimore, Maryland 21215-0036	and 2 shoul lealth and I em 27 is ma her treums			aughter	32	210 N.	Lei	and Number or Ru. Sure Wo				p Code) Spring MD	
more	Pege 1 annot to the sout: If ite	7	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State	cemetery	Disposition (Nai , crematory or o ntic C:	ther plac		Date / 20 / 12		ocation - City or en Bur	r Town, State 'nie MD	
Balti	permit. Departr Importe eny inju	21. Signature of Funeral Service Licensae Tho:							mplici	ty	Crem &	Fun Serv	
E	hysician/		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of immediate Cause (Final disease or condition	plications that caused the ne cause on each line.	death. Do no	et enter the mod		_	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to (or at a con	sequence of):	•						
	uted d ensit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	sequence of):							
	te be executed nysician and he burial-trensit		resulting in death) Last	Due to (or as a con	sequence of):							
. Box 68760	To the Hospitel or Attending Prysicien: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	23c. If yes, outcome of pro 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death	3 ☐ Ectopic 5 ☐ Other (s _i		ey			23d. Date of de Month	elivery Day Year	
ds, P.O.	quires that t en signed b ould be deta	Ď	Part II. Other significant conditions of	ontributing to death but no	t resulting in	the underlying	cause giv	ven in Part I.		_		o the cause of death? Probably 4 Unknown	
Division of Vital Records,	The law rec cate has be	Completed							24a. Was autor perfo 1 Yes		prior to death?	rtopsy findings available completion of cause of	
ital	Physicien: T r this certifica aral director, p	Be c	25. Was case referred to medical examiner? 1 1 Yes 2 No	Hospital:			Oth	ace of Death (Chec					
on of V	nding Physath. ath. r: After this re funeral d	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Yea	28b. Ti		8c. Injun work	4 LJ Nursing H ∕at	ome 5 Residence 128d. Describe h			cify)	
Division	el or Attend s after death i Director: A od in by the f	Certificate:	3 Suicide 6 Could not b 4 Homicide determined			n, street, factor	, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_	he Hospitt in 24 hours he Funere pletely fille	Medical	(Check 2 L Medical Exami	sician: To the best of my ki iner: On the basis of examin se Practitioner: To the best	nation and/or	investigation, in	my opinic	on, death occurred a	at the time, date a	and place	and due to the	cause(s) and manner stated.	
	with com		29b. Signature and title of certifier	MD				8513			te signed (Mont		
	10 Mg		30. Name and address of person who co	completed cause of death (/pe, Print)	rur	iest, B	thou	m	D		
	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 7 2012	32. Registrar's Si	ignature	aked.		•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a.perFH.G936.2/13/2013.WS
State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 19, 2012 Vivian Morris Smith 2:07PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min 09/21/1930 225-36-1965 Director 1 □ M 2 👿 F 82 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's New Carrollton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5302 85th Ave Apt C6 20784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Black 1 ☐ Yes 2 X No Specify. Specify Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the Teacher Education Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Morris Georgette Spurlock 19a. Informant's Name/Relationship (Type, Print)
Deborah Morris Daug 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Daughter 5302 85th Ave Apt C6 New Carrollton MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crem 12/23/12 Glen Burnie MD 21. Signature of uneral Service License 22. Name and Address of Facility Simplicity Crem & Fun Serv nons ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (as a consequence of) Examiner Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or injury and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical 25 years or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 52119 12-22-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHATRATHI; 7500 HANOVER Parkway; Swite 105A; Greenbelt, MO SRIDHAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ELEANORA LILLIAN SAUBLE Day Month Physician/ 520 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Medstar Union Memorial Hospital N/A If Under 1 Year If Under 24 Hrs. . Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Days Hours Min (Month, Day, Year) 212-34-2720 **Director** 1 🗆 M 2 🖾 F 76 June 24, 1936 Maryland 1 Maryland Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ar than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Maryland N/A Baltimore 28a-f 1 X Yes 2 No 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other them."-any injury or other traumait. 1434 Woodall Street 21230 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2 No 1 Yes 2X No Specify: Specify: White If Yes, Give 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Parks and Elementary/Secondary (0-12) College (1-4 or 5+) Recreation Recreation Director Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ernest M. Sauble Eleanor K. Schaaf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Bailiffs Court, Lutherville, Maryland 21093

#101 Anna Z. Roberg (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 🙀 Cremation 3 🗀 Removal from State 12/18/2012 Bayview Crematory, Inc. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Signature of Funeral Service Licensee Kevin E Ecker 130 East Fort Avenue, Baltimore, Maryland 21230-4513 M00175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Ne disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). attending physiclan and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No 2 ER/Outpatient 3 DOA 4 Nursing Home Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Accident (Month, Day, Year) 5 Pending work? 1 🗌 Yes 2 🗌 No within 24 hours after death. To the Funeral Director: A neral Director: A filled in by the f M Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, ocarn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

7 2012

breed a Delouen Meds me union Memorial Hospital, 201 Fast university Packway, Baltimore, Mary land

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Smith 12=36 PM Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of many and Meetral Ch Bultimae Caux Baltimere Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 212-46-8443 Month Day, Year) 46 Mary land **Director** 64 1 □ M 2 🗗 F 27 is merked other then "neturel", or items 23e or 28a-f show treumetic event, the Medical Examinar must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 ☐ Yes 2 ¥ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7734 Lee Drive 21122 U.S.A. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give ۾ Maryland 21215-0036 Il Hygiene. other then "neturei", 1 Yes 2 No Specify: Completed 3 Wildowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) C&P Telephone Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ည James Smith Mary Unknown t. Page 1 end 2 should be thment of Health and Men rtent: If item 27 is merke njury or other treumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Smith (cousin) 1009 1st Street Glen Burnie. Marvland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Cremation Date 20c. Location - City or Town, State permit. Page Department o Importent: If eny injury or injury or 1 Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 12-20-2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mounatin Road Pasadena, Maryland Kelley 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final Due to (or as a consequence of): nset and Death Physician/ a mirul valve ase or condition Medical resulting in death) Éxaminer Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificete be executed 24 hours after deeth. by the certificate has been signed by the ettending physicien end betakel **Director**. After this certificate has been signed by the ettending physicien end letely filled in by the funeral director, page 2 should be detached for use es the burlal-tren that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE yes, outcome of pregnancy
Live Birth 2 Live Beath 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 3 🔲 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by covanavy avtery disease 1 Yes 2 No 3 Probably 4 Onknown atrial fibrilation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? tailure VIINAI 1 Yes 2 No 25. Was case referred to examiner?
1 Yes 2 No 8 26. Place of Death (Check only one) Hospital: မ Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending ☐ Accident ☐ Suicide 1 ☐ Yes 2 ☑ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medica To the Hospi within 24 hou To the Funer completely fil 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my office and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one P27209 ttle of certifier 29b. Signature 29d. Date signed (Month, Day, Year) 12 18 ess of person who completed cause of death (Item 23a) (Type, Print) Ahmae Ballmore MD S. Evere St Date filed (Month, Day, Year)

NFC 2 7 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Social Security Number 219-40-0812 **Funeral** Age (In lyrs, last birthday) If Under 1 Year If Under 24 Hrs. / 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director Country) 1 X M 2 □ F 68 Yrs. 06/27/1944 MD Usual Residence of Decedent or then "neturel", or Iteme 23e or 28e-f show 10b. County within 72 hours efter death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Directo MD N/ABaltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 1507 Kenhill Ave. U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Gres 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dept. Of Transp. 9th Supervisor permit. Page 1 and 2 should be filed Department of Health and Mantai Hy, Importent: If Item 27 is merked othe eny injury or other traumath... Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Spencer Shirley Sewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1507 Kenhill Ave. Baltimore, MD 21213 Annie D. Thomas (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 12/28/12 Pikesville, MD Druid 21. Signature of Fun ral Service Licens 22. Mr. Funeral Home PA MD 21217 Fulton Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Myocordia **Medical** Examiner Cotonory a Sequentially list conditions, it any leading to immediate cause. Enter Underlying attending physician and I for use as the buriei-transit Exami The law requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE: 3b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No signed by the at id be detached for Pregnant at time of death Month Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours efter death.

To the Funeral Director: After this certificate hes t completely filled in by the funeral director, page 2 s autopsy death 1 ✓ Yes 2 ☐ No performed' Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗆 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41846 9 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

hiemann

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

avid Taylor		1- For State	Department o ה Certificate o		and Ment	al Hygiene	2.0	112 1.1051
Physic	ian/	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate	Dealli		2. Date of D	Reg. No. 2U	3. Time of Death
edical Exam							Day Yea Der 11, 2012	
		4a. Facility Name (if not institution, give street and number	er)	4b. City, Town,	or Location o		4c. County (
		Saint Agnes Hospital		Baltimore	•		N/	'A
Funera		5 Social Security Number 6. Sex 7.7	Age (In yrs. last birthday)	If Under 1 Y		A dise		9. 8 irthplace (State or Foreign Country)
Director		212-78-1086 1XM 2 F	53 Y		ays Hours	Min. 04/0	1/1959	MARYLAND
иу		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation				10d, Inside City Limits
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arylan 3a-f st	턍	MARYLAND N/A 10e. Street and Number		10f. Zip Code		_	10g. Citizen of Wh	
he Ma 1 or 23 iffed 3	Director	2600 H EDANIZITN CT /D		212			U.S.A	•
with 1 ns 23 ₂ be not	<u>a</u>	3600 W FRANKLIN ST. 4R 11. Marital Status 12. Was Decede				in? (Specify Yes or I		e - American Indian, Black,
death or iter	Funeral	1 XXNever Married 2 Married Armed Force	s? If	Yes, specify Cul	ban, Mexican,	Puerto Rican, etc.)	White	e, etc.
after ral", o	Ę,	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 X			Specify:	BLACK
hour 'natu	te d	15. Decedent's Education (Specify only highest grade c Elementary/Secondary (0-12) College (1-4 c	during	ent's Usual Occu most of working		ind of work done use retired)	16b. Kind of 8u	usiness/Industry
36 hin 72 e than	^호	Elementary/Secondary (0-12) College (1-4 c		CKER			MARK	ζET
5-00 ed wit lygien other he Me	Completed	17. Father's Name (First, Middle, Last)	5100		18.Mother's	Name (First, Middle		
be fill Firked	Be	ROBERT MACK			MAR	GIE F. TA	YLOR	
D 2: should and Me	욘	19a. Informant's Name/Relationship (Type, Print)	19b. Mailii	ng Address (St	reet and Numb	ber or Rural Route N	umber, City or Tow	n, State, Zip Code)
, MI and 2 sealth a eath a		Robert Mack Sr./ Father 20a. Method of Disposition	20b. Place of Dispo	2 Willis	ston St	., Baltim		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 XXBurial 2 Cremation 3 Removal from S			cemetery,	Date	20c. Location -	- City or Town, State
Itimen partmen present		4 Donation 5 Other Specify 21. Signature of Emeral Service Licensee	ARBUTUS 1			12-20-12	BALTIMO	ORE, MARYLAND
Ba Perm Depz Imp		(IMPreserve)	W.	ILLIAM (206 W NC	BROWN	COMMUNIT	Y FUNERAI	L HOME P.A.
Physician		23a. Part I. Enter the disease, or complications that cause	d the death. Do not enter	the mode of dyir	ng, such as car	rdiac or respiratory a	rrest, shock, or hea	art Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a Methadone an	d Cocaine Intoxicat	ion				8etween Onset and Death
LAdimici		or condition resulting in death) Due to (or as a con						
	-a	Sequentially list conditions, if any, leading to immediate Due to (or as a con	sequence of):					
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vecuted n and - transit	Exa	events resulting in death) Last Due to (or as a con	sequence of):					
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	ical	d. UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome.						
60, rate be exe physician ne burial -	Med	IF FEMALE: 23c. If yes, outcome	ome of pregnancy				23d. Date of	delivery
Box 6876(death certificate the attending phy dofor use as the b	cian/	23b. Was decedent pregnant in the past 12 months?	t time of death	etal death 3	3 Ectopic	pregnancy	Month	Day Year
30x death e atter	Physic	1 Yes 2 No 9 Unknown 9 Unknown	at time of death 5 0	ther (Specify)				
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of Vital Records, ng Physician: The law requir ther this certificate has been si meral director, page 2 should b	Completed					24a. Wa		Vere autopsy findings available
teco	E O					pen	formed? d	leath?
	BeC	25. Was case referred to medical		26.Pla	ice of Death (C	Check only one)	2 10 1	Yes 2 No
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n of Vital ding Physician: After this certif		27. Manner of Death 1 Natural 5 Panding FOUND:	ury 28b. Time of UNKNOW!		jury at Work?	Subject to	how injury occurre	ed
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Division ital or Attendii us after death.	Certification:	determined (Coopital L	njury - At home, farm, stre	et, factory, office	e building, etc.	28f. Location or Town,	(Street and Numbe State) in Street , Baltimo	er or Rural Route Number, City
Hospin 4 houn Tuner:		29a. Certifier		erod at the time	data and slee			
Divisic To the Hospital or Atte within 24 hours after dea To the Funeral Director completely filled in by th	Medical	one) 2 Medical Examiner: On the basis of ex	amination and/or investiga	ation, in my opini	on, death occu	e, and due to the car urred at the time, dat	use(s) and manner e and place, and du	as stated. ue to the cause(s)
Son Tairi	Š	29b. Signature and title of certifier		29c. Lice	nse number		29d. Date signe	ed (Month, Day, Year)
		Carol Hallan		0.0	C.M.E.		December 1	12, 2012
Oth		30. Name and address of person who completed cause of	, ,					
Ω.	لبي	Carol H. Allan, MD Assistant Medical E			reet, Baltin	nore, MD 21223	3	
St Regis		31. Date filed (Month, Day, Year) DEC 2 7 2012	ar's signature					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19631A-M Dec Flinn Thompson Nancy Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BAHIMOre Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Director 1 M 2 T 85 1927 Sept. Maryland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. It is marked other then "netural", or Items 23e or 28e-f show ther treumatic event, the Medical Evaniner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 148 Sanford Avenue 21228 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 XNo 3altimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced Completed White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1st National Bank Bank Teller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Earle Newman Sharp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Thompson (Son) <u>906 Lee Avenue.</u> Sykesville. Maryland 21784 Department of Health Important: If item 2 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 12/22/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Stephanie Custer Macnabb Funeral Home, P.A. Road, Catonsville, Marvland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE Pnysician disease or condition Medical resulting in death) Examiner INFECTION UNKNOUL fany, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) is certificate has been signed by the a director, page 2 should be detached t g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HUPERT ENSION 1 Nes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy To the Hospital or Attending Physicien: The i within 24 hours after death.

To the Funerel Director: After this certificate it completely filled in by the funeral director, page Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signati MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 31. Date filed (Month, Day, Year) 32. Registrar's 6ignatur State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C938 4/25/2013 IH State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylar				Mental Hy	ygiene	9				
	_		Registrar 1. Decedent's Name (First, Middle, Las	st)	Cer	tificate of D	<i>peatn</i>	2. Date of D	Reg. No	2012	141956			
	Physici Medi		David Randall Ti	gnor, Jr.						Ž3, 2012	5:10 P M			
	Exami		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Deat			. County of Death	3.10 1			
	1		Carroll Hospital	Center		Westmins	ster			Carrol1				
н	Funeral		5. Social Security Number 6. S		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi		9. Birthp Coun	place (State or Foreign			
	Director		Usual Residence of Decedent	⊠ м2□F 49	Yrs.			Dec 1						
	and shov	þ		10c. Cit	ty, Town or Loc	ation					0d. Inside City Limits			
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	th wit ns 23 must	Funeral	3217 Old Washingt	on ka.		21048				ted State	·S			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.	۾	1 Never Married 2 Married	12. Was Decedent Ever in U.3 Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	li li	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 🛣 No	n, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Americ Black, White, e Specify: Whi	etc.			
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and	be file antal F ked o c eve	일		C			18. Mother's Na	, ,		Surname)				
Maryland	ould Me		David R. Tignor, 19a. Informant's Name/Relationship (Ty		40h M-10-				Pickett Route Number, City or Town, State, Zip Code)					
	12 shalth ar 27 is r trau		Mary A. Tignor (M	, ., ,		g Address (Street al Carter Rd					Code)			
Je,	1 and of Hei		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of	Ť	Date	_	ocation - City or To	wn, State			
Ē	Page nent c ant: If		1 Burial 2 K Cremation 3 4 Donation 5 Other (Specific			atory or other place 1 Cremato	•	29/ 2013	l	infield,	·			
Baltimore,	permit. Departr Import. any inji		21. Signature of Fundation (Continue)	Olar	Bu	Name and Address	s of Facility	ral Home	e and	l Cremato	rv. P.A.			
		r	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the deat	h. Do not enter	12 W. 01d r the mode of dying	Libert , such as cardiac	or respiratory a	infic rrest,	1d, MD 2	178/i			
-	Pnysician/	8)	Immediate Cause (Final disease or condition		oval.	e mic	Than	d.			Interval Between Onset and Death			
	Medical Examiner		resulting in death)	a. Due to (or as a consequ	uence of):	C THE	2 1100	K						
	Examiner	<u>.</u>	Sequentially list conditions,	b. Seve	re t	tnew	119							
	od sit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of).	n h	1							
	icate be executed g physician and as the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as a consequ	LACA	nc 1	reopl	asm						
0	be ex sician buria	Sall			.o		•							
120	icate g phys			d										
Box 68	death certific he attending led for use as	Physician/N		23c. If yes, outcome of pregnal						23d. Date of delive	rv			
ĝ	ss that the death certi igned by the attendin be detached for use	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown		Ectopic pregnancy Dther (specify)					Day Year			
P.O.	t the by th	훒	9 Unknown											
σ.	Attending Physician: The law requires that the yr death. The After this certificate has been signed by the funeral director, page 2 should be detach by the funeral director, page 2 should be detach.		Part II. Other significant conditions co	ntributing to death but not res	ulting in the un	iderlying cause give	n in Part I.	23e. Díd t	obacco u	se contribute to the	e cause of death?			
Division of Vital Records,	require been si should I	Completed by						1 😡	Yes 2	□ No 3 □ Prob	ably 4 🗆 Unknown			
ပ္သ	law r has b	훁						24a. Was auto			sy findings available apletion of cause of			
E E	: The icate r, pag		05.111					1 🗆 Yes	2 No	death?	2 No			
īfa_	sictar certif irecto	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		26. Plac	e of Death (Chec	k only one)						
3	Physic rethis eral d	9: 10	27. Manner Leath	1 Inpatient 2 28a. Date of injury	ER/Outpatient 28b. Time of	3 DOA	4 L Nursing H			Other (Specify)				
Ë.	nding ath. : Afte e fun	cat	1	(Month, Day, Year)	injury	work?		28d. Describe I	iow injury	occurrea				
isi	il or Atteno safter death Director: d	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor				28f. Location (5	Street and	d Number or Rural I	Route Number			
Š	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2			building, etc. (Specify)				City or Tox			,			
	Hospital 24 hours Funeral I etely filled	Medical	29a. Certifier 1 Certifying Phys. (Check 2 Medical Examir	cian: To the best of my knowled er: Dn the basis of examination	edge, death oc	curred at the time,	date and place, a	and due to the ca	ause(s) an	nd manner as state	d.			
	To the within 24	Me	only one) 3 🗆 Certifying Nurse	Practitioner: To the best of m	y knowledge, o	leath occurred at the	time, date and p	ace, and due to t	the cause(s) and manner as st	se(s) and manner stated. ated.			
	≒ .≱ 6 8		29b. Signature and title of certifier	MAL TA	<i>N</i>	29c. License r	number M 5-11	710	29d. Date	e signed (Month, D	ay, Year)			
U)		20 Name and address of	VICY IVI	₩	10-0	007	- 10	12	- 77.	12			
			30. Name and address of person who co	empleted cause of death (Item	23a) (Type, Pri	7 Mal	calmid	rive,	We	HMUNI MD2	tela			
	Stat		31. Date filed (Month, Day, Year)	32 Negistrar's Signatu	2	41				1,17	1131)			
	Registra	ir	DFC 2 7 20	12 / James 6	7. DU	LEGIF								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 20/3 Maria Tate 2:15 Medical Decembr 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ba HOSDI NA TIMOSE 917 Social Security Numbe If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 11-27-49 9. Birthplace (State or Foreign Days Hours Min. Director 216-50-4012 Country 1 □ M 2 F 63 Yrs Usual Residence of Decedent r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notifled at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4829 Williston Street 21229 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces? Black, White, etc. African ᅙ 1X Never Married 2 ☐ Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Yes. Give 1 Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify: American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than College (1-4 or 5+)
2yrs. Elementary/Secondary (0-12) 12th Grade Administrative Manager State of Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Sadie Belle Tate, Sr. Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Anthony Timpson-Son 5819 Carpenter Street Philadelphia, PA 19143 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12-29-12 Catonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician, Onset and Death 4cute disease or condition weeks Medical resulting in death) Due to (or as a consequence of): Examiner hear +21 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events months Due to (or as a consequence of): Exami signed by the attending physician and d be detached for use as the burial-trans.t Breast or Attending Physician: The law requires that the death certificate be executed (ancei Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed certificate has been si lirector, page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🕅 No the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 은 2 🔀 No 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the fi 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier the 29b, Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) exande a 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 41958 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec. Tate 2012 0624 А м Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Ritchey Hospice NA Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Yea 09-30-52 Days 214-54-4602 1 🛛 M 2 🕮 F Director 60 MD Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 28a-f 1 Yes 2 No Baltimore NA MD 10e. Street and Number 10 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1706 Presbury Street USA 21217 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Armed Forces? Black, White, etc. African þ 1x Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: American Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) various Trades 12th Grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 2 Belle Daniels Sadie Tate, Sr. John Ε. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1342 James Street Baltimore, Maryland 21223 Nicole Tate-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 12-29-12 Catonsville, MD Metro Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. Gilmor_Street Baltimore, Maryland 21217 638 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tra Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 2 🗸 25. Was case referred medical 26. Place of Death (Check only one) examiner' 2 **V** No Other: မ 1 Yes 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760 BSOPH Tate Hospital or Attending Physician: To the within 2

DHMH 17 Rev 06-2011

State Registrar

24 hours after deat Funeral Director:

Medical

✓ Natural

4 Homicide

(Check

Accident

29b. Signature and title of certifie

Suicide

5 Pending

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

injury

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and named as stated.

D00576

28f. Location (Street and Number or Rural Route Number,

in the Baltmore MDZ122

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5260 East

Al	ŒND	#25, PER ME G934 1	Type or Print in B	Black Indelible In	k. Ensure A	Il Copies A	Are Legi	ble.			
		For State Registrar	State of Maryland	Certificate of L			g. n 2 ()	2	41959		
	ician/ edical	1. Decedent's Name (First, Middle, Las Alcida Van	iten			2. Date of Death Month	_プ ay プラ	Year	3. Time of Death		
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Fune		5. Social Security Number 6. S	ex 7. Age (In yrs. las	st birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	<u> </u>		ce (State or Foreign		
Direction Direction		Usual Residence of Decedent 10a. State 10b. County	□ M 2 ØF 8 9	Yrs. Town or Location		353	4 1	lethe			
Marylan 28a-f sh	Director		6	Hersville,	MD			100	I. Inside City Limits 1 ☐ Yes 2 ☑ Nio		
with the	eral D	10e. Street and Number	nct	10f. Zip Code		10	g. Citizen of W	hat Country	l3		
r death	y Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	ispanic Origin? (Spec an, Mexican, Puerto F	rify Yes or No- Rican, etc.)	14. Race	- American , White, etc			
21215-0036 within 72 hours after glene.	ted by	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1 Yes 2 No			Specify:	Whi	te		
215- iin 72 ho le. han "na	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		16a. Decedent's Usual Occup (Give kind of work done of life. PO NOT use retired)	during most of working	g 16	6b. Kind of Bus	siness/Indus	stry		
nd 21 liled with Il Hygien other ti	Be C	17. Father's Name (First, Middle, Last)		HOMEMA	18. Mother's Name	(First, Middle, Ma	iden Surname)	<u>1 Ho</u>	ME		
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show	욘	HENDRIK TO			DEB	ORAT	TOKKI	E			
re, Ma 1 and 2 sho of Health and item 27 is n	Y.	19a. Informant's Name/Relationship (T)	EN SON	19b. Mailing Address (Street	151 0	i .	-	ate, Zip Coo	de)		
O 0 + 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State cer	ace of Disposition (Name of metery, crematory or other place	ce) D	ate 20	Oc. Location - 0	City or Towr	n, State		
Baltimo permit. Page Department Important I	once.	21. Signature of Funeral Prvice Lines		22. Name and Addre	ss of Facility	SCHERT	y FUNK	RALF	tomE		
		23a. Part 1. Enter the disease, or comshock, or heart failure. List only o	MOO942	Do not enter the mode of dyin	g, such as cardiac or	respiratory arrest	AMD.		pproximate		
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Box he death of the atter	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23d. Date of de Month 1								
5, P.O. Signed by signed by the detail	d by P	Part II, Other significant conditions co	ontributing to death but not resul	ting in the underlying cause given	ven in Part I.				cause of death?		
cords	Completed by					24a. Was an autopsy	24b. W	ere autopsy	r findings available		
ii Rec	Com	25. Was case referred to medical		ac Di	ace of Death (Check	performe 1 \(\sum \) Yes 2.	ed? de	ath?			
Vita hysicia his certi	To Be	examiner?		R/Outpatient 3 DOA Oth	er: 4 Nursing Hon		ce 6 🗆 Other	(Specify)			
on on or and ing Pratter 1. After 1	Certificate:	27. Manner of Death 1. ■ Natural 5 □ Pending 2 □ Accident □ Investigation	(Month, Day, Year)	lab. Time of injury 28c. Injury work 1 □	y at ?? Yes 2 \(\sum \) No	8d. Describe how	injury occurred	1			
Division all or Attendings after death.	Certii	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	2	8f. Location (Stree City or Town, S		or Rural Ro	oute Number,		
Hospitz 24 hours Funeral	Medical	(Check 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination a se Practitioner: To the best of my	and/or investigation, in my opinio	on, death occurred at t	he time, date and p	place, and due t	the cause	(s) and manner stated.		
To the within To the complex	Σ	29b. Signature and title of certifier	se Practitioner: To the pest of my	29c. License	number	290	. Date signed	Month, Day			
		30. Name and address of person who c			3054	N	OVENBE	2 22	, 2012		
		MAJID CINA	JENNIFER ROAD.	ANNAPOLIS, ~	(D. 21403						
	State strar	31. Date filed (Month, Day, Year) NFC 27 20	32. Aegistrar's Signatur	J. Jackey							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ Mari 2:34 AM 720\ 7 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wedster Hurter Baltimor HOSP ita Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country Director 274-20-7314 1 □ M 2 🕅 F 89 Jan. 27, 1923 Scotland | 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Anne Arundel Linthicum 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Coronet Dr. 21090 United States 11 Mantal Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs. Social Security Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Differ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Elizabeth Brannen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James W. Vykol Linthicum, MD 203 Coronet_Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Park 12/22/2012 | Glen Burnie, Maryland 21. Signature of Funeral Sc 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Intarction Myocardia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consiquence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DO 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manger of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, December 20, 2012 . Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Fort Lienve 31. Date filed (Month, Day, Year) State 32. Registrar's Sjgnature Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Vilonik LIVO 7:13 PM December Medical 25 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Center Randallstown BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Davs Hours (Month, Day, Year) **Director** 111-86-8784 1 🛛 M 2 🗆 F Yrs. 79 04/22/1933 UKRAINE er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits NY KINGS BROOKLYN 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4520 4TH AVENUE. #C509 11220 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ulth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **METAL** WORKER **FACTORY** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. BORIS VILCHIK ETTEL MAMUT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) POLINA PANINA/NIECE 3 PENDRAGON COURT, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/26/2012 BALTIMORE HEBREW REISTERSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Delerium superimposed dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician end I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury int that initiated events resulting in death) Last bue to (or as a consequence of) Physician/Medical resolved Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consequent at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ě chronic inflammation 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an 24 hours after death.

Funeral Director: After this certificate has etely filled in by the funeral director, page 2. autopsy performed? Yes 2 M No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗆 Yes 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 028462 December 25 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest Center Randallstown Maryland HOSPITON 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

State

Registrar H DHMH 17 Rev 06-2011 DEC 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41962 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year THOMAS WILLIAMS US: 18 PM DECEMBER Medical 2012 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEDSTAR HARBOR HOSPITAL BALTIMORE N/A Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 218-36-9840 Director 1**X** M 2 □ F 70 Yrs. 02/07/1942 Usual Residence of Decedent S. Carolina show 10a. State notified at Director 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 28a-f N/A Baltimore 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code must be i 10g. Citizen of What Country? Funeral 546 5th Ave. 21227 U.S.A. items 2 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or ite Medical Examiner 14. Race - American Indian, Armed Force 1 Never Married 2 Married þ Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) e filed within.
al Hygiene.
't, the Mer' 16b. Kind of Business/Industr (Specify only highest grade completed) Dinner Elementary/Secondary (0-12) College (1-4 or 5+) Harlequin Theater Chef Be 17. Father's Name (First, Middle, Last) should be file and Mental F 18. Mother's Name (First, Middle, Maiden Surname) Thomas J. Robinson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic Azilie (UNK) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Scruggs (Daughter) 546 5th Ave. Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State On-Site Crematory 5 ☐ Other (Specify) 12 Baltimore, MD 22. Name and Address of Facility Brown, f Funer I Service Licensee Jr. Funeral Baltimore, Jr. 2140 N. Fulton Avé. MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of): **Examiner** PULMONARY HYTERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed CHRONIC OBSTRUCTIVE PURMONARY DISEASE g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical d. IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No oage 1 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes ျ Other: 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident the Investigation

Division of Vital Records, P.O. Box 68760

within 24 hours a

To the Funeral D State

Registrar DHMH 17 Rev 06-2011

filled in by

Medical

Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) **DEC 2** 7 2012

W) s draws

4 Homicide

29a. Certifier

6 Could not be

determined

SOUTH HANGVER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR NAIR, MEDSTAR WARBOR WOSPITAL,

STILLET, BALTIMORE

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

RES 001

MARYLAND

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M.D.

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

DECEMBER 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2 Perate of Maryland 2/37/20112nt by Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Dorothy Marie Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Franklin Rose Baltimore ware os pita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 168-16-2991 Director 93 1 □ M 2 🗚 F 11-23-1919 PA or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore County Baltimore 1 ☐ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a the proportant: If item 27 is marked other than "natural", or items 23a that jointy or other traumatic event, the Medical Examiner must be proce. Funeral 21236 USA 2 Campton Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Specify: white 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Owner Home maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Harvey Shive 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Campton Court, Baltimore MD 21236 Patricia Y. Leber/daughter 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State Date 12/17/2012 Catonsville MD 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ a Acute Myocardi disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ardiovascu Sequentiany liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical cholestero Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 2\ N 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 D Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0023704 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William Andrew 9000 Franklin Samuere Drive Baltimore, MD 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 22, 2012 Daniel Raymond Weber, Sr. 3:40 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Lorien Mays Chapel Nursing Center Lutherville Baltimore County S. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 **X** M 2 □ F Hours 90 Director 218-18-2281 July 14,1922 Morgan Co. TA7 7.7Z Usual Residence of Decedent or 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Lutherville 1 Yes 2X No ō 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ms 23a or must be Funeral within 72 hours after death with 1431 Burton Ave. 21093 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian er than "natural", or iten the Medical Examiner Armed Forces? orces? U.S.Amy Black, White, etc. 1 Never Married 2 Married X Yes þ Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give W.W.II 3 X Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien

27 is marked other tl
traumatic event, the 05 Heavy Equipment Mechanic Heavy Equipment Repairs N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve ence. 0 Raymond Floyd Weber Daisy Florence Henderickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Linda L. Hanzsche / Daughter 1426 Burton Ave. Lutherville, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State Baltimore County Date cemetery, crematory or other place)

Dulaney Valley Memorial 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Thursday, Dec.27,2012 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland Cardens 21. Signature of Funeral Service Licensee Teffrey L. Cair, Sr. (FSP22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. 21092-2215 4. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 P. 1. Inter the disease, of complication that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cars on each lin Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury and trar that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physiciar Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ŏ Month Day Year the detached 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 A No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 or Attending 1 X Natural 5 Pending 1 Yes 2 No nours after death neral Director: A ifilled in by the fo Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and fitte of certifie

DHMH 17 Rev 7/2009

State Registrar cause of death (Item 23a)

2. Registrar's Sign

30. Name and address of person who completed

Year 7

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ 2012 James R. Weston, Jr. Medical December 11:25 P.^M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1339 North Bend Road Jarrettsville Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) **Director** 219-36-1561 15€M 2 □ F 73 June 16, 1939 Maryland Usual Residence of Deceden 10a. State 10b. County the Meryland ir then "natural", or items 23a or 28a-f eho The Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 ☐ Yes 2 😾 No Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1339 North Bend Road United States 21084 within 72 hours efter death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Black, White, etc. ۾ Yes 2 No Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 ℃ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) el Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Cabinet Maker Wood Working Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mentel ? is marked o ပ္ Department of Heelth end Ment. Important: If itam 27 is marked any injury or any James R. Weston, Sr. Wilma V. Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Carpenter-Breeding/Daughter 909 Lucabaugh Mill Road Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. 20a. Method of Disposition 20c. Location - City or Town, State Dec. Dat 22 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Dongtion 5 ☐ Other (Specify) 2012 Timonium, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & CremationService—BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Multiple disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospitei or Attending Physician: The lew requires thet the deeth certificete be executed within 24 hours after deeth.

To the Funerai Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ဂ္ 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the pasts of examination and investigation, it may optimize, the cause of the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Manson D0070043 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 North Charles Street Baltimore Maryland 21204 Robin Manson

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

	For State Registrar		C	ertificate of I	Death		Reg. No. 2	012	4196	
n/ al	1. Decedent's Name (First, Middle, Last)	Gaylor A	rlingto	n Watts		2. Date of Dea Month Decembe	Day	Year 2012	3. Time of Death 6:30 P.	
r	4a. Facility Name (if not institution, give stre	eet and number)			r Location of Death			unty of Death		
	Glen Burnie Health 5. Social Security Number 6. Sex		1- 4 binds 1-		Burnie			ne Aru		
		M 2 □ F 7. Age (III	yrs. last birthday 4 Yrs.	Months Days	Hours Min.	8. Date of Birt Menth Da 1	1928	9. Birth Cou	nplace (State or Foreigntry) Maryland	
Director	Maryland Anne Art		Dc. City, Town or Balti			=		10d. Inside City Limit		
Funeral D	10e. Street and Number 300 Grove Park R	oad		10f. Zip Code 212	25			of What Cou	intry?	
ج	11. Marital Status 12 1 X Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	in U.S. 10	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Giv	redent's Usual Occup re kind of work done DO NOT use retired) isabled		ing	16b. Kind	ndustry		
eu I	17. Father's Name (First, Middle, Last)	aylor Watt	s		18. Mother's Nam	Name (First, Middle, Maiden Surname) Marie Dankey				
	19a. Informant's Name/Relationship (Type, Print) Earl Watts / Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi, 300 Grove Park Road Baltimore, Mary									
	20a. Method of Disposition 1	and the second Objects	Glen Hav	position (Name of rematory or other place ren Mem. P	ark 12/2		Balti		Maryland	
	21. Signature of Funeral Service Consee	hidge		22. Name and Addre					e, P.A. yland 2122	
er	23a. Part 1. Enter the disease, or complications that decised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cina Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate b. Disease (Final disease) Due to (or as a consequence of):									
edical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Direct (or as a consequence of): C. Due to (or as a consequence of):									
	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of de 23d. D								very Day Year	
ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to Demustry 1 we will be a supported by the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the support of the sup							/	he cause of death? bably 4 🗌 Unknow	
Completed by						24a. Was a autop perfor	rmed?	tb. Were auto prior to co death? 1 \square Yes	opsy findings available ompletion of cause of	
Be	25. Was case referred to medical examiner?	pital:			ace of Death (Check	only one)				
<u>و</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 28a. Date of injury	2 ER/Outpat		4 Nursing Ho	me 5 Resid			/)	
Certificate;	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Ye	ear) injury	M 1 □	? Yes 2□No					
	4 Homicide determined	building, etc. (S	pecify)			City or Tow	n, State)		I Route Number,	
Medical	only one) 3 L Certifying Nurse P	On the basis of exam	ination and/or inve	estigation, in my opinion, death occurred at the	on, death occurred at e time, date and place	the time, date ar e, and due to the	nd place, and e cause(s) and	due to the ca manner as si	use(s) and manner sta tated.	
	29b. Signature and title of cartifier			29c. License	958		29d. Date sig	aned (Month, $-6/1$)	Day, Year)	
	30. Name and address of person who com-	pleted cause of death	(Item 23a) (Type	Print)			,	-	1021061	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Deirdre Lynn Williamson State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 22, 2012 **Medical Examiner** 1210 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8729 Loch Bend Drive #208 Parkville **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Min Director М 2 X F Country) Unk Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits timore 1 Yes 2 No 28a-f show with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Specify: White Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 4 Divorced if Yes, Give Year 1 Yes 2 No specify: other than "natural", the Medical Examiner than "natural", 至 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 KNCC Dancel 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Debora Dean stewart ဥ 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1730 Kona Rd Parkville a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 Cremation 3 Removal from State esapeoine (remunc. 4 Donation 5 Other Specify. Ata I stephen 21_Signature of Funeral Service Licenses 22. Name and Address of Facility Lohrmann P.A. Stephen D. Lohn Pr. Baltimore MD 21286 **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Between Onset and /Medical Death a Heroin Intoxication and Cocaine Use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, per me, g935 1-10-13 sm X UNPENDED attending physician or use as the burial -Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Year Day past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 V Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Vulknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed' death? Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 25 Was case referred to medical 26. Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA this 1 🗸 Yes 2 No 27. Manner of Death After 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 X No unknown death. filled in by the fd 12-22-12 fd 12:00 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8729 Loch Bend Dr. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined (Specify) Fd: Hotel/Motel within 24 hours. __ Homicide Towson, MD 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year, State Registra

29b. Signature and title of certifier

(Mul-Do

Ana Rubio M.D., Ph. D.

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

Assistant Medical Examiner

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d Date signed (Month, Day, Year)

December 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Martin White Month 20/2012 1:17 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 07/27/1947 212-50-2433 Director 1**X** M 2 □ F 65 MD ed other than "natural", or items 23e or 28e-f show event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3939 Roland Ave 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give 1 9 6 7 – 6 9 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Narried δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) and 2 should be filed within 7 Health end Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Lab Tech Medical 2yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothy Martin Thomas A. White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane White Health item 27 West 37th Street Baltimore MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1: Department of I Important: If its any injury or of once. 1 Burial 2 Cremation 3 Removal from State 12/27/12 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie MD Atlantic Crem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physiclen end I for use es the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav ed by the el detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β Records, Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy After this certificate To the Hospitel or Attending Physicien: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\text{3 Other (Specify)} \) 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. recember 20. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \sim 0 N. Charles 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician WHEATLES 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PARKWAY BALTIMORE Ba Gimore L PERRING Ceni If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 240-52-4858 Months Days Hours 1 □ M 2 🗶 F Director Oct 30 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examinar must be notified Director ARKVILLE 1 ☐ Yes 2 No BALTIMORE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1801 21234 4.5 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify hite þ 3 X Widowed 4 ☐ Divorced natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) l Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME permit Pages 1 and 2 should be filed with Department of Health, and Mental Hygienn important: If item 27 is marked other the any injury or other traumatic event, its once. HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN UNFNOWN 19a. Informant's Name/Relationship (Type. Print) Gumo/AN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shipp Hereore Md 21222 AVA NAUGH Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Arwall Cre 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State O denton, Harylows 12-27-2012 21. Signature of Funeral Service Lieussee 22. Name and Address of Facility ann CONKLING 21224 Approximate Interval Between Onset and Death 23a. P in 1. Enter the shock, or heart , or complications that caused the death. Do not enter the mode of dying, such as car like or respiratory arrest, list only one cause on each line. Immediate Cause Final disease or condition resulting in de xh) 10 years **Physician** EIM /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by TENS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Washing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □ No within 24 hours after death.

To the Funeral Director: 2 Accident the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) the 1

State Registrar

P.O.

Division of Vital

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

ERIC ANAPOISM

31. Date filed (Month, Day, Year) 32. Registrar's Signature

6095

30. Name and address of person who completed on se of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

		AM	1EN	D #12, PER	Please T FH, 25,2	ype or Pri 7,28A-F State of M	nt in l PER arylan	Black li ME G9 d / Dep	n delib 34 12 artmer	le Ini 17181 nt of F	, Ens lealth	ure A TRT and M	II Copie Iental Hy	s Are	e Legi	ble.		
				For State Registrar					rtificat					Reg. N	00	12	4	970
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		uneral irector		5. Social Security Numb 218-01-418		7. Ag		st birthday)	Months		If Under Hours	Min.	8. Date of Bir (Month, Da			9. Birthp Coun	olace (State try)	e or Foreign
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	ath w	ems ;	Funeral Director	11. Marital Status		2. Was Decedent	Ever in U.S	3. 13.			spanic Or	igin? (Spe	cify Yes or No- Rican, etc.)	-		- Americ	an Indian,	
9	fer de	or it	þ	1 Never Married		Armed Forces?	No		If Yes, spec 1 ☐ Yes]				Rican, etc.)			k, White,	etc.	
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2	Z1Z13-UU30 within 72 hours after	the N		Elementary/Seconda	ıry (0-12)	College (1-4 or	5+)	1	f Emp		đ			(Carpe	ntry		
	Mand 2121 dbe filed within 7	d oth) Be	17. Father's Name (First	, Middle, Last)						18. Moth	ner's Name	(First, Middle				•	
-	Maryiand 2 should be filed	ment narke	욘	Frederick		ybell		1			En	nma	W. I	Land	graf			
	Mar 2 shou	th and		19a. Informant's Name/					_	•			Route Numbe	-			Code)	
	and and	tem 2		Mr. Craig 20a. Method of Disposit	tion		20b. P	lace of Dispo	Was	me of			ooklyn , Date		_C_1_Z_Z _ocation -		wn, State	
	altimore, mit, Page 1 and	nt: If		1 ☐ Burial XX C 4 ☐ Donation 5 ☐	remation 3 ☐ Re	emoval from State	, α Δ+1	emetery, crei antic					6/2012			•		21061
3	alt.	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Junera			1 2203	2:	2. Name ar	nd Addres	s of Facil	ity Sin	gleton	Fun	era1	& Cr	emat	ion
42								S	ervic	es,	PA 1	2nd A	Ave SW	G1e	n Bun	rie,	MD 2	21061
					ilure. List on y one	ations that cause cause on each lin	d the death e.	n. Do not ent	er the mod	de of dying	g, such as	cardiac o	r respiratory a	rrest,			Approxim Interval E Onset an	Between
-		∕sician/ ∕ledical		Immediate Cause (Fina disease or condition resulting in death)	.i a.	DEM Due to (or as	ENT	r)A,	100	ZH	121	MS	12			-	Oriset an	u Deau
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		±	Examiner	Sequentially list conditi if any, leading to immed cause. Enter Underlying	diate	Due to (or as	a consequ	ence of):										
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		'a -≅	_	resulting in death) Last	L.	500 10 (0) 43	a consequ	ionoc on.					16	-/				
Š	56/50 sertificate b	g physicia as the burl	fedi		d.						A	1/4	1111	M EXA	MINER			
8		attending I for use	an/N	IF FEMALE: 23b. Was decedent pre	griant	c. If yes, outcome	of pregna	ncy Ideath 3	7 Ectopic	pregnanc	י -דובונו	APP NOITE	ONE BI	- 6	23d. Dat	e of delive	ery	
C	ISION OF VITAL RECORDS, P.O. BOX 68/00 Attending Physician: The law requires that the death certificate be	he att	Physician/Medica	in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	at time of d	leath 5	Other (s)	pecify)	CERTIFIC				Mor	nth	Day	Year
	that the			Part II. Other significar	nt conditions cont			-						tobacco	use contri	bute to th	ne cause o	f death?
	rest T	signe d be o	Completed by	MYELO	DYSE	LASI	A		, ,					Yes 2	. /			Unknown
	Kecords, The law require:	should I	olete	FALLS	= /								24a. Was		24b. V	/ere auto	osy finding	s available
6	he la	ite has page 2	шо	FIZAC:	runs:	D LE	-+	HIF	>				auto perfi 1 \(\hat{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tin}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tex{\tex	ormed?	d	eath?	mpletion o	of cause of
-		iis certificate has I director, page 2	Be C	25. Was case referred to examiner?	o medical					26. Pl	ace of Dea	ath <i>(Check</i>		2,001	3001000		22	
1	r Vital Physician	ω D I	욘	1 X Yes 2 X	o Ho			ER/Outpatie			<u>4 ⊔ N</u>		me 5 Res)	
	On OT ending P	After this	Certificate:	27. Manner of Death 1 Natural 5 2 Accident	Pending	28a. Date of inju (Month, Da UNK	y, Year)	28b. Time o injury UNK	т _м [2	28c. Injury work 1 🏻	/at ? Yes 2.[28d. Describe 1ULTIPL			d		
0	SIO Atten	ector: by the	ıtili	3 Suicide 6	Investigation Could not be determined	28e. Place of Inj	ury - At ho	me, farm, str			100 2 2	-	28f. Location ((Street a	nd Numbe	r or Rurai	Route Nu	mber,
K.	DIVISION Atte	al Dir	ဦ	T I Torrillolds		building, et HOME	c. (Specify)					City or To BROOKLY			WAS	ENA A	AVENUE
H	Hospital or	within 24 hours after dealin. To the Funeral Director: After Completely filled in by the fu	Medical	29a. Certifier (Check 2	Certifying Physici Medical Examine	ian: To the best of r: On the basis of e	my knowlexamination	edge, death and/or inves	occurred a	at the time my opinio	e, date and on, death c	d place, ar	nd due to the o	ause(s)	and manne e, and due	er as stat	ed. use(s) and	manner stated.
17	To the	omple	Ĕ	only one) 3 29b. Signature and title	of certifier	Practitioner/ Total	e best of n	ny knowledge		curred at t		ate and pla	ce, and due to		e(s) and mate signed			
	F ?	- 0		· Ile	duradi	Zil-	M	D	3	DO	00	25	5/9	1ć	0/4	1//	2,, ,,,,,,	
1	(1+1)		30. Name and address	of person who con	apleted cause of o	death (Item	23a) (Type, I	Print)		1	/		7	1-	/ "		
	_			RICHAR		HER	550	255	KIT	CHI	5/1	IWA	Y, C	EC	OKO	yn), ZI	225
		Stat Registra		31. Date filed (Month, D	ay, Year) OFC 27 2	32. Registr	ar's Signat	ure \$	1.00	1		/	/ /			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	tate of Marylan	•				2011	41971		
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Jeath	2. Date of Dea	neg. No.	3. Time of Death		
	Physicia Medic		Sandra Abrams					Month 12	Day Yea 24 201	r		
The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	Examin	er	4a. Facility Name (if not institution, give stree Holy Cross Hospital	t and number)		4b. City, Town, or Silver S	Location of Death		4c. County of Do Montgome:			
	Funeral Director	11		7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 11-1-193	y, Year)	Birthplace (State or Foreign Country) BW YORK		
	iryland 9-f show fied at	Director	Usual Residence of Decedent 10a. State		y, Town or Lo	cation	l	1		10d. Inside City Limits 1 🔀 Yes 2 □ No		
	or 286		10e. Street and Number	1,000	TOIN	10f. Zip Code			10g. Citizen of What			
	s 23a	Funeral	200 East 78th Street	PH-8		10075			United State	3S		
920	within 72 hours efter death with the Maryland glene. er then "neturel", or Items 23a or 28e-f sho the Medical Emarther must be notified at		1 Never Married 2 Married	Nas Decedent Ever in U.S Armed Forces? I ☐ Yes 2 X No f Yes, Give Year or Dates.	1	Was Decedent of H f Yes, specify Cuba □ Yes 2 汉 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc. Jhite		
Baltimore, Maryland 21215-0036	filed within 72 hours efter death with the Maryland at Hygiene. An ethygiene and the first state of the work of other than "neturel", or Items 53s or 28s-f show event, the Madical Examination of the work.	Completed by			(Give I life. D	lent's Usual Occup kind of work done o O NOT use retired) Relations	ation during most of work	king	16b. Kind of Business/Industry Advertising			
land 2	d be filed w Jental Hygi irked other	To Be	17. Father's Name (First, Middle, Last) Emmanual Erlbaum	,	Tubile	KCIGUIONO	18. Mother's Nan 8etty Di		Maiden Sumame)			
Mary	d 2 should be file laith and Mental H n 27 is marked o er treumetic eve		19a. Informant's Name/Relationship (Type, P Andrew Abrams - Son	rint)					r, City or Town, State, yland 20901	Zip Code)		
more,	permit. Page 1 end 2 Department of Health Importent: If item 27 eny Injury or other to once.		20a. Method of Disposition 1 【☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	emetery, cren	sition (Name of natory or other place Cemetery		Date 28-2012	20c. Location - City			
Balti	permit. I Departn Importe eny Inju		21. Signature of Funeral Service Licensee	8rian Deibler	- 1	Name and Addre	- 0	,	Goldberg Mem aryland 2085	orial Chapels 2		
I	Physician/		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition	ons that caused the death use on each line. Respiratory Fai		er the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):		D:-					
	sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ		ructive Pu	Lilionary DIS	ease				
09	ate be executed physicien end the burial-transit	dical Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
. Box 687	death certifica ne ettending p ed for use as	Physician/Me	in the past 12 months?	f yes, outcome of pregnal Usive Birth 2 Peta Pregnant at time of d	ldeath 3	Ectopic pregnand Other (specify)	су		23d. Date of Month	delivery Day Year		
s, P.O	ires that the dea signed by the e lid be detached t		Part II. Other significant conditions contributions Failure To Thrive	uting to death but not res	ulting in the u	nderlying cause gi	ven in Part I.			e to the cause of death? Probably 4 🛣 Unknown		
Division of Vital Records, P.O.	Physicien: The law requires that the this certificate has been signed by the director, pege 2 should be detach	Completed by						24a. Was autop perfo 1 Yes	osy prior ormed? death	autopsy findings available to completion of cause of ? Yes 2 \square No		
ita	iclen: The certificate rector, pe	Be	25. Was case referred to medical examiner?	tal:		26. Pl	ace of Death (Chec	k only one)				
n of V	To the Hospitel or Attending Physicien: Within 24 hours after death. To the Funerel Director. After this certific completely filled in by the funeral director,	cate: To	ILI fes 2 MAI NO	1 No Inpatient 2 28a. Date of injury (Month, Day, Year)	ER/Outpatier 28b. Time of injury	at 3 □ DOA 28c. Injur work	4 ∐ Nursing H yat		dence 6 Other (Sp now injury occurred	pecify)		
Division	Hospitel or Attending 24 hours after death. Funerel Director: After stely filled in by the fune	Certificate:	3 Suicide 6 Could not be	8e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,		
_	o the Hospitel Ithin 24 hours of the Funerel I	Medical	29a. Certifier (Check only one) 1 X Certifying Physician 2 Medical Examiner: 0 Certifying Nurse Pra	On the basis of examination	and/or invest	tigation, in my opinio	on, death occurred a	at the time, date a	and place, and due to t	he cause(s) and manner stated.		
_	Velth Com		29b. Signature and title of certifier		MID.	29c. Licens DDD641			29d. Date signed (Mo	onth, Day, Year)		
	100		30. Name and address of person who comple Smitha Bhikkaji, MD - 1	eted cause of death (Item ISDD Forest Gle			ring, Maryl	and 2D91D				
	Stat Registra		31. Date filed (Month, Day, Year) DEC 2 8 2012	32. Registrar's Signat	ture fast							

DHMH 17 Rev 06-2011

Please	Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
	State of Maniford / Department of He	nolth and Montal Hygiana

		1- For State Registrar	Ce	rtificate of	Death		R	teg. No.	12 41916
Physic edical Exam		Decedent's Name (First, Middle,La JAELIN DAI	·				2. Date of Dea Month Decembe	Day Year 20, 2012	3. Time of Death 0645 hrs
		4a. Facility Name (if not institution, gi Laurel Regional Hospital		4	b. City, Town, o Laurel	r Location of Dea	th	4c. County o	
Funeral Director			Sex 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Yes		n.	rth(MM/DD/YYYY) 1/1997	Birthplace (State or Foreign Country) VA
ow any		Usual Residence of Decedent 10a. State 10b. County MD ANNE AB		, Town or Location	on				10d. Inside City Limits 1 Yes 2 X No
MOTE, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If time 27 is marked other tran "matural", or items 23a or 28a-f show any or other transmatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 3502 CARRIAGE			10f. Zip Code 20724			10g. Citizen of Wh	
eath with the items 23a ust be noti	uneral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Ever in U. Armed Forces?		Decedent of Hi	ispanic Origin? (\$ n, Mexican, Puert			- American Indian, Black, , etc.
ours after d atural", or		3 Widowed 4 Divorce 15. Decedent's Education (Specify of	d If Yes, Give Year	16a. Decedent		ation (Give kind of		Specify:]	BLACK siness/Industry
11215-0036 It be filed within 72 hours after Aerial Hygiene. aarked other than "natural", event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) 8th	College (1-4 or 5+) NA	STUD		e. DO NOT use re		SCHOO	ΣĽ
D 21215-00; should be filed with and Mental Hygiene 7 is marked other the matic event, the Mes	Be Co	Name (First, Middle, Las VANN DERRICK Informant's Name/Relationship (ASHE, II	10b Mailing	Addross (Cha	TONYA	YAVETT	Maiden Surname)	SON , State, Zip Code)
e, MD 2 1 and 2 shou Health and Initera 27 is no	<u>۵</u>	TONYA Y. JACKS	ON- MOTHER	221 F	ORESTE	R CT.,	APT D	RICHMO	OND, VA 2322
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specif	Removal from State RO	Place of Disposit crematory or oth SELAWN MORY G	er place)		Date /28/201		City or Town, State Allen, VA
	_	2 Si nature of Funeral Service Ince	nsee Le	2MA 43	RCH^#7	H ^{FWE} ST BASH A	VE, BAI	TIMORE	, Md 21215
Physician /Medical Examiner			each line. . Multiple Injuries		e mode of dying	ı, such as cardiac	or respiratory an	rest, shock, or hea	rt Approximate Interval Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence o						
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence or Due to (or as a consequence or						
760, icate be executed physician and the burial - transit	ical E	UNPENDED	AMENDED						
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death Runeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preging 1 Live birth 4 Pregnant at time of de	2 Feta	al death 3 er (Specify)	Ectopic pregn	nancy	23d. Date of o	delivery Day Year
O. Bo t the deat by the at ached for	문	Part II. Other significant conditions	9 Unknown	esulting in the ur	nderlying cause	given in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?
ls, P.O quires that the en signed by	ted by						1 Ye		Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requints after death and Director: After this certificate has been silled in by the funeral director, page 2 should t	Completed						autor perfo 1 ✓ Yes	osy pr ormed? de	rior to completion of cause of earth? Yes 2 No
Vital hysician: this certi	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ✓	ER/Outpatient		e of Death (Check Other 1 Nursi	only one)	Residence 6	Other:
ion of Vita tending Physicis eath tor: After this ce the funeral direct	-	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investiga	28a. Date of Injury FOUND: Top Dec 20, 2012	28b. Time of In FOUND: 0559 hrs		yes 2 ✓ No		how injury occurre lestrian struck	d by motor vehicle
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could no determine	t be 28e. Place of Injury - At ho		, factory, office I	building, etc.	or Town, S		r or Rural Route Number, City ort Meade, MD
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examine	cian: To the best of my knowledger: On the basis of examination at and manner stated.	_	on, in my opinion	n, death occurred		and place, and du	ue to the cause(s)
	×	29b Signature and title of certifier	Her Jan	· .) .	29c Licens	M.E. 03	in I am	29d. Date signe December 2	d (Month, Day, Year) 21, 2012
		70. Name and address of person who Theodore M. King, Jr., MI			00 W. Baltir	more Street, E	Baltimore, MI	D 21223	
s	tate	31. Date filed (Month, Day Year)	32 Registrar's Signatu	back	11				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 23, 2012 6:45 р м G. Arnett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 3160 Gracefield Rd. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Director 90 218-12-3323 1 M 2 X F Maryland Jan. 13, 1922 sual Residence of Deceden filed within 72 hours over tal Hygiene.
ad other then "neturel", or items 23e or 28a-f ehow
event, the Medical Example must be notified at 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location Director 1 Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 USA 3160 Gracefield Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Administration age 1 end 2 should be filed wit ent of Heelth end Mental Hygien ht: If item 27 is marked other i y or other traumetic event, ID. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unknown) Lillian George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2806 Willow View Ct., Hampstead, MD. 21074 John Buchheister, Jr. (Cousin) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 12/29/12 Baltimore, Maryland permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenseal 3620 Wilkens Ave., Baltimore, MD. 21229 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 20nset and Death COPD Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 읻 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗖 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State
Registrar

DHMH 17 Rev 06-2011

Julaine Harding, CNP,3110 Gracefield Rd., Silver Spring, MD. 20904

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

3. Registrar's Signature

31. Date filed (Month, Day, Year)

DEC 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bentley Month Gladys 1310 1 2012 12 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death University of Maryland Medical Center N/A Baltimore MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In vrs. last birthday Director 577-32-2369 1 M 2 XF 88 Yrs 11/01/1924 MD Usual Residence of Decedent or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits State 10b. County with the Maryland Director MD N/A Baltimore 1X Yes 2 ☐ No and Mental Hygiene. Is marked other than "natural", or items 23a or ? aumatic event, the Medical Examiner must be m 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1428 Carroll St. 21230 U.S.A Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. The free 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper 11th John Kraft Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Arthur Scott Janet Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Moore (Daughter) 2818 Rayner Ave. Baltimore, MD 21216 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site Crematory Baltimore, MD of Fu eral Service Licer 22Josephreno Fabrown, Jr. Signatur Funeral Home PA 2140 N. Fulton Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1mmediate Cause (Final Providen/ bleedin GastrointestMal disease or condition . Medical resulting in death) **Examiner** ASION Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be a thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physicia the Funeral Director: After this certificate has been signed by the attending physicia mpletely filled in by the funeral director, page 2 should be detached for use as the burn publetly filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancer Breast 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 2 No ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of 29d, Date signed (Month, Day, Year) 1720303811 12/25/2012 f death (Item 23a) (Type, Print) 30. Name and address of person who completed cause street Baltimore MD 21201 South Greene 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 06-2011

DEC 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryl				Mental Hy	giene 2012	1,1975
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of L	Death		Reg. No.	
П	Physicia		Nancy LM Brown				2. Date of De	Day Year	107 a . > M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Deat	Decem	4c. County of De	
	C		Northwest Hospital		Randa	illstown	\sim	Balti	more
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🕱 F 7. Age (In y	yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1h 9. E	Sirthplace (State or Foreign Sountry)
			Usual Residence of Decedent				1 01/01	1/1924	D.C.
	ryland I-f sho ied at	cto		c. City, Town or Loc Pikesvi]					10d. Inside City Limits
	he Ma or 28a notif	Dire	10e. Street and Number	11/05/11	10f. Zip Code			10g. Citizen of What	1 Yes 2 No
	s 23a	Funeral Director	1315 Saddleback Rd.		21208				U.S.A.
	r item		11. Marital Status 12. Was Decedent Ever in Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	nerican Indian, lite. etc.
036	s after ral", o Exam	Completed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2 🏿 No	Specify:		Specify: B	lack
2-0	2 hour "natu	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation Juring most of wo	rkina	16b. Kind of Busines	s Industry
121	ithin 7 ene. * than	Com	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DC	NOT use retired)		9	Balto. C	ity Schools
d 2	Illed w Il Hygi I other vent, I	Be	17. Father's Name (First, Middle, Last)		Journ	18. Mother's Na	me (First, Middle,	Maiden Sumame)	
ylar	ld be i Menta rarked atic er	2	William Martin			Maggie	Haskel	L1	
Nar	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Ϋ́	19a. Informant's Name/Relationship (Type, Print) Beverly Jeffress (Dghtr.					r, City or Town, State, . esville,	
ē,	f Healf item 2 other			0b. Place of Dispos	sition (Name of	-	Date	20c. Location - City	
imo	Page 1 ment of ant: If it ury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		natory or other place Cremate		28/12	Baltimor	e, MD
Baltimore, Maryland 21215-0036	permit. Page 1: Department of I Important: If it any injury or of		21. Signature of Full eral Service Licenses	22:	J'orsephidae	of FaBit Ow	n, Jr.	Funeral	Home PA MD 21217
	.,		23a. Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.						Approximate Interval Between
\sim	hymnian/	'n	Immediate Cause (Final disease or condition	D					Onset and Death
Sec.	Medical Examiner		resulting in death) Due to (or as a cons	sequence of):					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):					-
	cuted ind transit	Examiner	Cause (Disease or imjury that initiated events c						
	ate be executed ohysician and the burial-transit	dical E	resulting in death) Last Due to (or as a cons	sequence of);					
290	icate t g phys	ledic	d						
Box 687	ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre 1 □ Live Birth 2 □ □		Ectopic pregnanc	v		23d. Date of o	delivery
Bo	res that the death certifica signed by the attending p d be detached for use as t	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown in the past 12 months? 4 Pregnant at time 9 Unknown		Other (specify)	,		Month	Day Year
P.O.	that th		Part II. Other significant conditions contributing to death but not	t resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	v requires been sign should be	ted k					1 🗆 '	Yes 2 No 3 No	Probably 4 Unknown
cor	law re nas be e 2 sho	Completed by					24a. Was autop	osy prior to	autopsy findings available o completion of cause of
Re	n: The icate I		25. Was case referred to medical				1 \(\text{Yes}	rmed? death? 2 ☑ No 1 ☐ Y	
/ita	/sicial s certii	To Be	examiner? Hospital:	2 FR/Outpatient	Lou	ace of Death (Che		6 □ Oth (0-	- 25. 4
of	ng Phy ter thii neral o		27. Manner of Death 1 ✓ Natural 5 □ Pending 28a. Date of injury (Month, Day, Year,	28b. Time of	28c. Injury work	at		lence 6 Other (Spe ow injury occurred	эспуу
ion	ttendii death. tor: A: the fu	Certificate:	2 Accident Investigation		M 1 □	Yes 2 ☐ No			
Division of Vital Records,	al or A s after I Direc d in by		4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	at nome, tarm, stre	et, factory, office		281. Location (S City or Tow	treet and Number or F in, State)	Rural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my kn (Check only one) 3 Certifying Nurse Practioner: To the best of examination only one) 1 Certifying Nurse Practioner: To the best of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro	ation and/or investi	igation, in my opinio	n, death occurred	at the time, date a	nd place, and due to the	e cause(s) and manner stated.
	To the vithin 2 To the comple	2	29b. Signature and title of certifier	.,	29c. License	number		29d. Date signed (Mor	
			1 / m (_ M.1).		1206	26:0		Decembe	V 26,2012
	21		30. Name and address of person who completed cause of death (I		rint) Randal	(Stoler)	MD 211		
	Stat Registra		31. Date filed (Month, Day, Year) 32. Figures's Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Significant Signi	an at we	ale	.5100010			
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	Physici /Medic		1. Decedent's Name (First, Middle, Last)	osse				2. Date of Dea Month		
	Examir Funeral Director		4a. Facility Name (If not institution, give streen FRANKLIA Social Security Number 6. Sex 218-26-3566 1 M	HOSPIT	(In yrs. last birtho	Rollay) If Under 1 Year	or Location of Death Seda (If Under 24 Hrs. Hours Min.	8. Date of Birth	9.B	ath #1 0
	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltimor		0c. City, Town c	r Location				10d. Inside City Limits 1 ☐ Yes 2K No
3	23a or 28	ral Director	10e. Street and Number 1618 Middleboro	ough Roa	ad	10f. Zip Code 21221			l 0g. Citizen of What 0	
036	be fled within 72 hours after death with the Maryland tall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, it a Medical Examination in the notified at	by Funeral	1 Never Married 2 Married	Was Decedent Eve Armed Forces? 1 □ Yes 2X No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cub 1 □ Yes ※ No		cify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, ite, etc. Ihite
215	illed within 72 hg Hygiene. Other than "natu ent, It e Medical	Completed	15. Decedent's Educati (Specify only highest grade co Elementary/Secondary (0-12) 10th	on ompleted) College (1-4or 5+)		ecedent's Usual Occup Give kind of work done fe. DO NOT use retire Iomemaker	oation during most of workin d)	g	own hom	•
Maryland 2	Duld be med Mental Hy larked othe latic event,	To Be C	17. Father's Name (First, Middle, Last) George Berk				18. Mother's Name Emma	Kern		
, Mar	and 2 sn ealth and n 27 Is m her traum	8	19a. Informant's Name/Relationship (Type. David Bosse /so		16	Mailing Address (Street 518 Middl	eborough	Road	Baltimor	e MD 21221
altimore,	permit. Fages I and z should be I Department of Health and Mental Important: if item 27 is marked or any Injury or other traumatic eve once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		isposition (Name of crematory or other plac Cemetery		29/12	Essex MD	
Balt	Depart Depart Import any Inj once.		21. Signature of Funeral Service Licenses	la					Ave. Bal	
	hysician /Medical xaminer		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	Heart	AHA	ck		r respiratory an	rest,	Approximate Interval Between Onset and Death
ב ב	attending physician and for use as the burial-transit	al Examiner	Sequentially list conditions, and the sequential between the sequential between the sequential between the sequential between the sequential sequential initiated events resulting in death) Last							
DOX	O O	Physician/Medica	in the past 12 months?	If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at til 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	ру		23d. Date of o	lelivery Day Year
ecords, F.O	been signed by the should be detached	ρ	Part II. Other significant conditions contrib	outing to death but r	not resulting in th	ne underlying cause giv	en in Part I.			to the cause of death? Probably 4 🗗 Onknown
vital Records,	cate has bee	Completed						24a. Was a autop: perfor 1 ∐Yes	sy prior t med? death'	autopsy findings available o completion of cause of ? es 2 □ No
	certifi	Be	25. Was case referred to medical examiner?	nital:		Ott	26. Place of Death			
5	rthis ral dii	F.	I tes SE 140	1 Inpatient 28a. Date of Injury	2 ER/Outp	atient 3 DOA	4 Li Nursing Hon		ence 6 Other (S) ow injury occurred	pecify)
VISION	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day,) 28e. Place of Injury	/ear) Inju	ry Wor	lYes 2□No	8f. Location (S	treet and Number or	Rural Route Number,
בוֹינוֹ	nours afte		4 Homicide determined	building, etc.		leath occurred at the ti	ime, date and place, a	City or Tow		as stated.
3	n 24 h	Medical	(Check only 2 Medical Examiner one)	: On the basis of ex and manner state		or investigation, in my	opinion, death occurre	ed at the time, o	date and place, and d	ue to the cause(s)
, <u>,</u>	vithii To th	Me	29b. Signature and title of certifier	mi	D	29c. Licens	se number		29d. Date signed (Mo	
	151		ALA TANFIC Ahi	leted cause of dea	00 FR					
	Sta Registr		31. Date filed Month, Day, Year) DEC 2 8 201	2 Server	Cianatura					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Thomas Baynes Sr 11.20 AM Doc 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NAME HOSPITAL ROSEDAle BAltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Months 220 30 1225 Director 1 M 2 F October 25, 1928 Baltimore, Maryland item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must be notified at</u> 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 USA 1025 Bowleys Quarters Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Mantal Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 MMarried Saltimore, Maryland 21215-0036 1 ☐ Yes 2√X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 end 2 should be filed within 72 Department of Health and Mental Hygiene. 1 Important: If item 27 is marked other than 1 any injury or other traumatic event, the Mea gnote. Elementary/Secondary (0-12) College (1-4 or 5+) Wholesale Flower Industry N/A Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ann Marie Boettcher John George Baynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1025 Bowleys Quarters Road Baltimore, Maryland 21220 Isabel C. Baynes (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2012 Parkwood Cemetery December 28, Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home Inc . Signature of Funeral Service Licenses 7401 Relair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Que o (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) this certificate has been signed by the arral director, page 2 should be detached g 🗀 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 KNo To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifics completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No 1 ₹Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural
Accident
Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Crutifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square DrivE BAltimore, MD 2 1237 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #4b Pestate of Maryland 9 Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2512 Robert Mack Bond Jr. Medical 4a. Facility Name (if not institution, give street and number) LOCH ROVEN Community Livi Examiner 4b. City, Town, or Location of Death 4c. County of Death LIVINA enter Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Days Country) Director 216-20-9373 1 🛛 M 2 🗆 F 27 01 27 NC r then "neturel", or items 23a or 28e-f shov the Medical Examinar must be nutified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 🛚 Yes 2 🗆 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 109 Wheeler Ave 21223 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Xyes 2 No
If Yes, Give s filed within 72 hours after de tal Hygiene. ed other then "neturel", or it Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Postal Clerk Federal Employee na 8 land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file of Mental marked o Josephine Peeples Robert Mack Bond Sr. Bond 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Union Hall Ct., Catonsville, Md 21228 Cynthia Renee Bennett Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1
Department of
Important: If it
eny injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Garrison Forest Vet 1/3/2012 Owings Mills, 21. Signature of Funeral Service Licenses March For Howest 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on eachyline. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Prostate Immediate Cause (Final disease or condition Metas Cancer Tal Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter United lying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): ed by the attending physician and detached for use es the burial-transit or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 9 🗌 Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has prior to completio death? After this certificate 2 1 No 1 Tes To the Hospital or Attending Physiclan: I within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I BB B 25. Was case referred medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 1 ☐ Yes 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier License number 041365 2012 och Raven Boulevard 30. Name and address of person who dompleted cause of death (Item 20a) (Type, Print) 21218 and State gistrar's Signatur Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 26, 1:41 PM PHYLLIS JOAN BUREK 2012 Medical 4a. Facility Name (if not institution, give street and number **Examiner** County of Death Prince George's 4b. City, Town, or Location of Death Laurel Regional Hospital Laure 5. Social Security Number Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Days Hours **Director** 209-28-1672 1 □ M 2 🛛 F 76 June 18, 1936 Pennsylvania Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1XXYes 2 ☐ No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 921 Carroll Avenue 20707 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, Elementary/Secondary (0-12) College (1-4 or 5+) Grade 12 Property Management Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James P. Larkin Helen Herr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 3617 Sundown Farms Way Olney, Maryland Sharon E. Bland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5XXXOther (SpecifyEntombment Parklawn Mem. Park Jan 3, 2012 Rockville, Maryland 21. Signature of Euro ral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Pneumonia Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician a detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by ate has been signed page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No 1 Pinpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No I Director: After the funeral 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be within 24 hours after d

To the Funeral Direct
completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 00063580 12.26.12 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Regional Mina Yacoub, MD Laurel Hospital Laurel

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

OEC 2 8 2012

2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Margaret Physician/ Elizabeth Barlage **Month** 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 6. Sex . Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 264–60–5600 Months Days Min Director 1 M 2 StF 72 12/21/39 MD f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho: other traumatic event, the Medical Examiner must be notified at. or 28a-f shov 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XXes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1817 Jackson Street 21230 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event than the train. 1 Never Married 2 KM Married Completed by 1 ☐ Yes XX No If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Specify 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Joseph Schilling Lillian Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Barlage, Sr./Husband 1817 Jackson Street, BAltimore MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2XXCremation 3 Removal from State cemetery crematory or other place)
Cremation Center of MD 12/21/12 Hanover Maryland 4 Donation 5 Other (Specify) ²² Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Ave, Baltimore MD 2 Sign rule of Funeral Service Licensee Victor P Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final My occupation Physician/ disease or condition Medical resulting in death) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 🗌 Yes 2 🗌 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tyes 2 🗌 No hours after death Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours 29a, Certifie 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier Signature, 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person sekollen wim Memorial

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Sanature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 6:26 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Agnes Baltimore OSPITA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth Days Hours Min (Month, Day, Year) 7-3 Director 1 M 2 D F ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene, ant: If Ifem 272 is marked outher than "natural", or items 23a or 28a-f sho ant: If Item 277 is marked outher than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10g. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No 11mors 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 'REGG 20a. Method of Disposition 20b. Place of Disposition (Nam Date 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite cemetery, crematory or other place injury or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice any in 22. Name and Address of Facility MID 23a. Part 1 Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tail disease or condition resulting in death) WEEKS Medical Du t (or as a consequence of): Examiner 3 week omonas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 🗵 No ည 1 A Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending м ☐ Accident Investigation Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 2012 lecember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ma HIMORE ato 32. Pajistrar's Signature 31. Date filed (Month_Day, Year)

DHMH 17 Rev 06-2011

State Registrar

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Bryan Clay Bawtinhimer	State of Maryland / Department of Health and Mental Hygiene
1- For State	Certificate of Death

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1	¥	29b. Signature and	title of certif						290	. License	e number			29d. Da	ate signed	(Month, D	ay, Year)
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				0				`									
		30. Name and addr							n W Ba	ltimore	Street	Baltim	ore, MD	21223			
		Ana Rubio I					al Examin	- 3U	∨ vv, ⊔d		Oli GGL	,	, 1810				
	State	31. Date filed (Mon				n .	s Signature	E.	de								
Regi	stra	1	IFC 2	3 201	6 6	enera	J 13.	14904	VV								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DEC. DENISE MARIE BETZ 2012° 6:08 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE TOWSON GILCHRIST HOSPICE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Director 1 M 2 T F 56 212-70-8332 Yrs OHIO 4/20/1956 Usual Residence of Deced items 23a or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location traumatic event, the Medical Examiner must be notified at Director 1 Ves 2 No NOTTINGHAM MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral I USA 21236 6 SURREY LANE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 5 Completed by 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 💢 No Specify: Specify: 3 X Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION <u>OFFICE MANAGER</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SYLVIA PIVETTA ANTHONY FRASCHILLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4215 DARLEIGH RD NOTTINGHAM, MD 21236 KRISTOPHER BETZ-SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 12/28/12 BALTIMORE, MD GARDENS OF FAITH 4 Donation 5 Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME Signature of Funeral Service Licensee BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Enter the disease, or complications that caused shock, or heart faile. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ etastofi disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No erei Director: After this certificate hes been signed by the atter filled in by the funerei director, page 2 should be detached for v Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Tes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after deeth. 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funerel DI completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) ignature and title of certifier 29d. Date signed (Month, Day, Year) 00071287 ess of person who completed cause of death (Item 23a) (Type, Print) Chelles # 4105, Baltimore, MD 21204

MH 17 Rev 06-2011

State Registrar

31. Date filed (Month)

10

67

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 20 Boslev 2*0*12 9:30AM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death County of Death Examiner Kossville Baltimore Baltimore, MD Manor Care If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 K MARCH 14,1960 Months Days Hours Min. MARYLAND **52 Director** 215-82-6362 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits show 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Pooles Erminal mount on without HARFORD STREET MD. Director 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21154 USA 2646 DUBLIN ROAD death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in the feath and Mental Hygiene. Thent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 □Yes 2X No If Yes, Give Year or Dates: Specify. \$ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME 12 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTHA CONE ROBERT SMELTZER ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2646 DUBLIN ROAD STREET, MD. 21154 JOHN D. BOSLEY, JR SON 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of I
Important: If ite
any injury or of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State GLEN BURNIE, MD ATLANTIC CREMATORY 1-5-2013 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL ATR 610 W. MACPHAIL ROAD BEL AIR, MD. 23a. Part 1. Enter the disease, or con-shock or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kectal Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cuss. (Cisase or jury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 Scierosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R120938 12-20-2012

State Registrar 31. Date filed (Mont)

DHMH 17 Rev 1/2001

ORIGINAL

8813 Waltham Woods Rd Suite 204 Parkville Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Many 12:00 PM Bollino **Physician** 25 Decembe 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 98 1 □ M 2X F Days 8/22/1914 WEST VIRGINIA Director 220-03-7793 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director MD NA BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 4213 SHAMROCK AVE 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: If item 27 is marked other than "r any Injury or other traumatic avent the street." Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AMY OURS ၉ JAMES G. OURS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SALVATORE BOLLINO-SON 5641 KAVON AVE BALTIMORE, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 12/29/12 BALTIMORE, MD 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME 21. Signature of Funeral Service License BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part 1. Biter the disease, or com, licatio is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one exise on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonta **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE:

23c. If yes, outcome of pregnancy

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHAM

KIEMANH 31. Date filed (Month, Day, Year)

DEC

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed or Attending Physician:

Division of Vital Records, P.O. Box 68760,

|--|

Be Completed by

Medical Certification: To

State

Registrar

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	al death 3 🗌 Ectop	oic pregnancy (specify)			d? No prior to death? No 1 □ Yes ce 6 □ Other (Special injury occurred) set and Number or Rustate) use(s) and manner as	Day	Year
Part II. Other significant conditions of	_		ing cause given in Part I.					
				24a. Was auto perfo 1 Yes		prior to death?	completic	dings available on of cause of o
25. Was case referred to medical			26. Place of De	eath (Check only	one)			
examiner? 1 X Yes 2 □ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Res	idence 6	Other (Spe	ecify)	
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred		
3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif		ctory, office		(Street and wn, State)	d Number or I	Rural Route	e Number,
	ysician: To the best of my kno niner: On the basis of examina and manner stated.							ause(s)
29b. Signature and title of certifier			29c. License number		29d. Date	e signed (Mor	th, Day, Ye	ar)

00069427

23d Date of deliver

December 25 2012

4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001 11595

within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 1 2012 9:00 A M Thomas T. Blanco Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery 17701 Eaglesham Place Olney If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 318-24-6385 1 XM 2 □ F 1929 Illinois Aug 12, 83 ?7 is marked other then "neturel", or items 23e or 28e-4 show treumetic event, tre Medical Eranion must be notified at permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth end Mental Hygiene. Importent: If item 27 is marked other then "neture!", or items 23e or 28e-1 shov eny injury or other treumetic event, the Medical Examinar Industrial 24 engines. 10h County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Olney MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20832 17701 Eaglesham Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Completed Caucasian Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Defense Contractor Aeronautical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Garcia Aurora Tomas Blanco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia M. Tetrault-Blanco/Wife 17701 Eaglesham Place Olney, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematory 12/23/2012 Woodbine, Maryland Final Signature of Funeral Service License 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 toule 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final Physician/ 4 ease or condition Lung Cancer Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit eral Director; After this certificate has been signed by the ettending physician and filled in by the funerel director, page 2 should be deteched for use es the buriel-trens sulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 🔯 No ဍ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 06-2011

18111 Prince Philip Dr. #300

62. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David B. Harding

8

31. Date filed (Month, Day, Year)

D35965

Olney, MD

December 21, 2012

20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19 State of Maryland / Department of Health and Mental Hygiene 0 | 2 State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 24,2012 Charles Bernard Barnes 0405 М Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death n/a Joseph Richey Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign MD Country) Funeral Days Hours Min. 1696271942 Director 70 217-40-1766 1 🕅 M 2 □ F Usual Residence of Deceder 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director MO n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 USA 1503 Ellamont Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married \$ 1 ☐ Yes 2 🔀 No Specify. Specify: Black "natural", Completed 3 □ Widowed 4 □ Divorced Year or Dates. other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Maintenance Technician Food Service Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Miles Lawrence Bernard Barnes 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Winans Way Baltimore, MD 21229 Dayonna Barnes / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🎑 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Park 12.29.2012 Baltimore, MD Signature of Funeral Ser John L. Williams Funeral Directors, 4517 Park Hights Ave Baltimore, MD 21215 23a. Pa 1. Enter the disease, or complication that complication shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Parlansons disease or condition ·acc Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other:
4 Nursing Home 5 Residence 6 Other Specify Ho 5010 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/24/12 D0057644 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5200 Gasten Ave. Baltimore MD 21224 Zache 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1988 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Louis Anthony Colon Physician/ Month 12/23 /2012 10:15pm^M Medical 4a. Facility Name (if not institution, give street and number)
1504 Latrobe Park Terrace 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 212-30-4842 Days Hours Min. 85 Director 1 X M 2 | F Yrs 12/15/1927 PR Usual Residence of Decedent is then "neture!", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours efter death with the Meryland 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XXes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? /xc/人 /0 :/5 p ア Maryland 21215-0036 Funeral 21230 1504 Latrobe Park Terrace USA 12. Was Decedent Ever in U.S. Armed Forces? Arm Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Army Black, White, etc. 1 Never Married 2 KM Married Completed by White 1XXYes 2 ☐ No Specify: Puerto Rican 49 - 52Specify: 3 Divorced 4 Divorced Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 i Department of Heelth and Mentel Hygiene. Importent: If item 27 is merked other then "no eny injury or other treumetic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Custom Tailoring 12 Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1/02/23/2017 9 Hernandez Luciano Colon Carmen Esmeralda 19a. Informant's Name/Relationship (Type, Print)
Mary E. Colon / Wife nb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1504 Latrobe Park Terrace, Baltimore MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cem. 12/28/2012 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home,
1501 E. Fort Avenue, Baltimore MD Signature of Funeral Service Licensee Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The iew requires that the deeth certificate be executed within 24 hours efter deeth.

To the Funerei Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensif Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5/ Residence 6 Other (Specify) 27. Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Z Accident injury work? 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, R130272 STELLA MARYS 21093 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULAWEY VACE MO 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2012 Bernard Colton РМ 7:02 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Days Months Hours Min. (Month, Day, Year) Director 087-05-1251 1 **X** M 2 □ F Yrs New York 12-8-1917 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any once. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Silver Spring Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #408 20906 15100 Interlachen Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes 1 Yes 2X No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Ŕ 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4 or 5+) Retail Printer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည (Unknown) Philip Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Colton - Son 125 Chesapeake, Annapolis, Maryland 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 12-20-2012 Olney, Maryland Judean Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Danzansky-Goldberg Memorial Chapel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory apout shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): On Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or Injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Dysphagia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown peen 24b. Were autopsy findings available prior to completion of cause of Dementia 24a. Was an After this certificate has autopsy performe Critical Fracture 1 ☐ Yes 2 ☐ No Yes 2 X No eral Director: After this certific filled in by the funeral director, 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 X Yes 2 □ No Other: |@ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniun ☐ Natural 5 Pending Accident Suicide 1 Yes 2 No Slipped from Bed 6:00 РМ Investigation 12-6-2012 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 15100 Interlachen Home 24 hours Medical 29a. Certifie 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and close to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of quath (Item 23a) (Type, Print) 8600 Old Georgetown Drive, Bethesda, Maryland 20814 Anitha Pesala Chetty, MD -31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 2 8 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gretchen Matthews : 35 AM Dec 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center 5. Social Security Number 6. Sex 17. Age (In vrs. last birth Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 218-28-4884 1 M 2XXF 83 May 15, 1929 Maryland permit. Paga 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health end Mantel Hyglene. Importent: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show any fujury or other traumatic event, the Medical Evantisher must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Towson Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 526 Stevenson Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. Ś 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 - Widowed 4 - Divorced Specify: white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Howard B. Matthews Gretchen Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Stevenson Lane Towson, MD 21286 James Crews husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗌 Burial 2 🖾 Cremation 3 🗋 Removal from State 4 Donation 5 Other (Specify) 12/ 29/ 2012 Baltimore, MD Crematory 21. Signature of Funeral Service Lice 22. Name and Address of FMittchell Wiedefeld Funeral Home, INC 6500 York Road Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ vertebral disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CERTIFICATION NPPROVED BY MEDICAL Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying or Attending Phyalcian: The law raquiraa that tha daath certificate ba axecuted ed by tha attending physician and datachad for use as tha burlei-transif Cause (Disease or injury that initiated events etroper tonea Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificeta 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Fall from stonding while picking 1 Natural injury 5 Pending daeth. 1 ☐ Yes 2 No within 24 hours aftar daeth

To the Funeral Director: A

complately filled in by tha f 2 Accident 3 D Suicide Dec 232012 Investigation OOPM 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 526 Steven Son Livie nome edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 | Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) Day ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Physician: The After this certificate 1 ☐ Yes 2 ☐ No 2 6 No 25. Was case referred to edical the funeral director, **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) |ဇ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred To the Hospital or Attending ✓ Natural☐ Accident 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Afcompletely filled in by the fu м Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 19, 2012 Annie Marie Caple 4:12 p. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Examiner 4c. County of Death Mcntghcmery Hely Cress Hespital 5. Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min (Month, Day, Year) Director 578-60-4356 1 □ M 2 🖔 F 69 Virginia January 3, 1943 Usual Residence in then "neturel", or items 23e or 28e-f show the Medical Exprehenment be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Prince George's MD 1 Yes 2 No Capital Heights 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 704 Clcvis Avenue death \ 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ≦ 1 ☐ Yes 2 1√2 No If Yes, Give X Maryland 21215-0036 Black 1 Yes 2 No Specify: 3 -Widowed 4 Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant Fccd Service Wcrker ge 1 and 2 should be filed wit nt of Heelth end Mental Hygie t: If Item 27 is merked other or other treumatic event, III Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file n end Mental H 7 is merked of Sadie Tuck Wister Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton J. Caple 5507 English Oak Drive, Killeen, TX 76542 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Pege 1 e Depertment of H Importent: If its eny injury or ott 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State December 29, 2012 4 Donation 5 Other (Specify) Suitland, MD Cedar Hill Cemetery 21. Signature of Funeral Service His nisee 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Avenue, Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition resulting in death) Sersis Weeks Medical Due to (or as a consequence of): Examiner Weeks Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Due to (or as a consequence of) of or Attending Physicien: The lew requires thet the deeth certificete be executed setre deeth.

Director: After this certificate has been signed by the ettending physicien and d in by the funerel director, page 2 should be detached for use es the burlel-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease 1 Yes 2 No 3 Probably 4 Unknown rthis certificete has been si brei director, page 2 should Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဂ္ဂ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hoepitel or within 24 hours eft To the Funerel Di completely filled in Medical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one title of certifier 29b. Signature ar 29c. License numbe 29d. Date signed (Month, Day, Year) D-32332 December 26, 2012

Registrar

State

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suresh K. Gupta, MD, 9801 Georgie Avenue, Suite 220, Silver Spring, MD 20902

32. Registrar's Signature

				State of Maryl				-	_	
			For State Registrar	State of Wary		rtificate of			. No. 2012	41994
	Physici		1. Decedent's Name (First, Middle, Last)	ante				2. Date of Death Month	Day Year	3. Time of Death
R	/Medic		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	h
No. of			Franklin Woods Cen		un lant hintholoud	Rosedal	e If Under 24 Hrs.	8. Date of Birth	Baltimore	
**	Funeral Director		5. Social Security Number 217-24-3370 Usual Residence of Decedent	w 2□F 83	yrs. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day, 12/10/19)	rear) Co	hplace (State or Foreign untry)
	yland low at		10a. State 10b. County		City, Town or Lo	ocation				10d. Inside City Limits
	a-f sh tifled	ctor	MD Baltimore	R	osedale					1 □ Yes 2√∑ No
	with th	Funeral Director	10e. Street and Number 9524 Shirewood Ct.			10f. Zip Code 21237		10	g. Citizen of What Co U.S.A.	untry?
	death	nera	11. Marital Status	2. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame Black, White	
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notifled at	by Fu	1 ☐ Never Married 2 ☐ Married 3 【② Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: Whi	
5-0	72 ho 'natur dical I	eted	15. Decedent's Educa (Specify only highest grade	ition completed)	1 (Give	dent's Usual Occup	durina most of work		6b. Kind of Business/	Industry
121	within ene. than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired ervisor	d)		Pepsi Cola	
d 2	ifiled Hygi other ent, t	Ç	17. Father's Name (First, Middle, Last)			-	18. Mother's Nam	e (First, Middle, M	aiden Surname)	
ylan	ould be Menta arked atic ev	To Be	Peter V. Cellante					Meushaw		
, Maryland 21215-0036	and 2 sho ealth and 1.27 is m er traum		19a. Informant's Name/Relationship (Type Donna M. Wills- Dau	ghter	3323	Berlin C			City or Town, State, 2 1009	Zip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		b. Place of Dispo cemetery, cre tlantic	osition (Name of matory or other plac Crematory	12/2		oc. Location - City or Glen Burni	
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Licenses	no Ron					neral Hom MD 21014	e of Bel Air Inc.
			23a. Part1. Erte the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line.						Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition resulting in death)	Colonomy	© 0					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as) cor	sequence of):					
		ner	Sequentially list conditions, if any, leading to immediate curse. Find a decrying	Due to (or as a cor	sequence of):					
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Gout Due to (or as a con	scannon of).					
120,		<u>0</u>		Periphul Va		nd				
Box 687	ertifica ing ph e as th	Med	IE EEMALE:							
P.O. Boy	w requires that the death certificate been signed by the aftending physi should be detached for use as the t	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome pf pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of de Month	ivery Day Year
	law requires that the as been signed by th 2 should be detache	y Pt	Part II. Other significant conditions cont		-				acco use contribute to	
ord	equire sen sig ould b	ted k	Adeiocouchoma neta	itani to liver	Nau Atiu	mon briss	ex locchin	1 ☐ Yes	s 2 No 3 P	robably 4 Unknown
Records,	e la has je 2	omple						24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of
or Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?			la.		th (Check only one		
or/	S S	မ	1 ☐ Yes 2 ☐ No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		4 Nursing H	ome 5 Resider	nce 6 Other (Spe	city)
OU	ffer	tion	Natural 5 ☐ Pending	(Month, Day Yea		Wo	rk? Yes 2∐No	28d. Describe no	w injury occurred	
Division	al or Atter after dea I Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - building, etc. (Sp.	At home, farm, st pecify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		cian: To the best of my er: On the basis of exal and manner stated.						
_	To th withir To th comp	Me	29b. Signature and title of certifier) MD		29c. Licens	3841 -		0d. Date signed (Monito	th, Day, Year)
1			30. Name and address of person who con Shushil Sayr, 110 - 22131	onleted cause of death	(Item 23a) (Type,	Print)		1234		
	Sta Registi		31. Date filed (Month, Day, Year).	32. Dietrar's S	Signature	and				
DH	IMH 17 Rev 1/2	001	DEC 20 EU	- 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DECEMBER 2012 LOIS CECH 12:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD FOREST HILL FOREST HILL HEALTH AND REHABILITATION Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) 10/26/1930 Director 212-26-0113 1 ☐ M 2X F 82 MT Usual Residence of Deced 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖾 No MD HARFORD FALLSTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2104 HAMPSHIRE DR 21047 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Force Black, White, etc. 2 1 Never Married 2 X Married 1 ☐ Yes 2 ☒ No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOME MAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ ARNO BEYER LILLIAN PEETZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMOTHY CECH-SON 2310 TUFTON SPRINGS LANE REISTERSTOWN, MD 21136 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If its
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, OAKLAWN CEMETERY 12/29/12 BALTIMORE, MD 21 Signature of Funeral Service License 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME 9705 BELAIR RD NOTTINGHAM, MD 21236 Part 1. Enter the disease, or compli ations that ca ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 250m Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and the for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown be detached the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical filled in by the funeral director, B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, hours after City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 5 032255 December 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 MD. 21014

DHMH 17 Rev 06-2011

State Registrar MACPHAIL

W.

Registrar's Signat

DAVID DUNN

31. Date filed (Month Day, Year)

BEL

AIR,

ROAD

State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year M Edna Medical Ruth December 2012 2:15A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lighthouse Senior Living Ellicott City <u>Howard</u> Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Director 219-46-4706 1 M 2 4 F 86 9/17/1926 Usual Residence of Decedent Maryland 10a State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "nature!", or items 23a or 28a-f sho enportent: If item 27 is marked other than "nature!", or items 23a or 28a-f sho in liny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Harford Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1307 Fordham Court 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 25 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 24 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Operator 0 0 1 Telephone Company 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HArtner Jenny unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Coster 1523 Everlea Rd. Marriotsville 21104 Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/24/2012 Air Memorial Bel Alr, MD 21. Signature of Funeral Service lice see 22. Name and Address of FacilitySchimunek Funeral Home of Bel Air Phail Road Bel Air, MD. 610 West Mac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e, mir Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury Hospitai or Attending Physician: The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 1 Yes Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Tes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ②Other (Specify) A 55, 5 ~ C, vy မြ 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death, se Funeral Director: After the pletely filled in by the funera Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the Hosp within 24 hor To the Fune completely fi (Check 3 Certifying Marse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific LAALAD Dorenhu 21, 2012. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LA7ERUS CEDAR COLUMBIA. MD 21044 31. Date filed (Mont) State 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23 Day Physician/ Dec. 2012 7:30 anv Louise Ε. Clinton Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1912 E. Lafayette Ave. n/a Baltimore 9. Birthplace (State or Foreign 24 Country) N C 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

Feb. 14, 7. Age (In vrs. last birthday) **Funeral** Days Hours Min **Director** 242-24-2344 88 1 M 2 D Usual Residence of Decedent of Mental Hygiene. marked other than "natural", or items 23a or 28a-f shormatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Mo n/a Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 1912 E. Lafayette Ave. USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Black Specify: Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Baltimore City Senior Campanion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Hattie Horton Mac Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1912 E. Lafayette Ave. Baltimore, Md 21213 Joan Clinton/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.4,2013 Baltimore, Md Gardens of Faith 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD 21213 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer of unknown Primary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) eral Director: After this certificate has teen signed by the attending physician and filled in by the funeral director, gage 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 \(\subseteq\) No s after death.

I Director: After this certificate 2 🗌 No 1 🗌 Yes 25. Was case referred to medical a 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗌 Yes 2 🖺 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-P Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057465 26/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IS RAWPAUSE MD 7835 Sm 1871 MV Bathmore MD 21209 NSKAJUPAKSEMD 203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 8 2012 racks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Reg. No. Physician/ 2. Date of Death 3. Time of Death December 26, 2012 Stephen John Cunningham Medical 1:40 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Pennsylvania 176-12-0092 Director (Month, Day, Yea 12/26/1920 1X M 2 | F 92 : if item 27 is merked other than "neture!", or items 23s or 28e-f ehov or other treumatic event, the Medical Examiner must be notified at Pege 1 and 2 should be flied within 72 hours aftar death with the Meryland 10a. State Director 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Timonium 1 ☐ Yes 2 🗓 No 10e. Street and Numbe 10f. Zip Code Funeral 10g. Citizen of What Country? 2525 Pot Spring Road 21093 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 KXYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. Completed 3 € Widowed 4 Divorced 1 ☐ Yes 2 ☒ No Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas J. Cunningham, III Margaret Ellen Boyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health eltern 27 i Kathleen K. Ourningham / daughter 604 Worcester Road Towson, Maryland 21286 20a. Method of Disposition permit. Pege 1 e
Department of H
Important: If its
eny injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20c. Location - City or Town, State Joseph Church Cem. 12/29/2012 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The iew requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has bean signad by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Month Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) examiner? ၉ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 2 Accident 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

ho-completed cause of death (Item 23a) (Type, Print)

670

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dec. Day 2012 ear Cobbs 13, Edith ам 1:13 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Univ. of Maryland Medical Cente N/A 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7 Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 🗆 M 2 🖼 F Hours Director Yrs 218-42-8333 MD Jun 22, 1944 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MD **Baltimore** 1 X Yes 2 No Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be re-Funeral 300 Cantata Court 21136 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married by Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 27 is marked other th: any injury or other traumatic event, the once. Housekeeper **Marriot Hotel** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jackson Cora Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Johnson 10919 Daniel Sim Court, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Dec 19, 2012 Lansdowne, Maryland Mt. Zion Cemetery Signature of Emeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 23a. Par 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of) Examiner 27 years <u>Metastatic Breast Cancer</u> Sequentially list conditions Examine if any leading to immedicause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Month Pregnant at time of death Unknown the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 X Yes 2 ☐ No မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director After this a completed filled in by the funeral dii 27. Manner of Death
X Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated P28370 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) trongen in belf Dec. 19, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Henry Andoh 22 S. Greene St., n Baltimore, Md 21201 31. Date filed (Month, Day, Year) 82. Registrar's Signature State back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:35PM Carolyn Verley Carey DECEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death n/a Levindale Hebrew Geriatric Center Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days 0*5/11/5/11*/95/1 218-56-1569 61 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD n/a Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1208 West Mosher Street 21217 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Family Services Day Care Provider Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lamenter Sample Norman Carey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other trau 116 N. Paca St #103 Baltimore, MD 21201 Onessia Nichols / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place Donatjon 5 Other (Specify) 12.29.2012 Cremation Ctr of MD Hanover, MD 21. Si na ure o Funeral Ser ic Lik John L. Williams Funeral Directors, P.A. 4517 Park Hights Ave Baltimore, MD 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ RESPIRATORY FAILURE ON MECHANICAL VENTILATOR disease or condition Medical resulting in death) Examiner NUEKS GANGRENE OF Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) 2 MONTHS Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi CEREBRO VASCULAR that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 d. IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year ate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 500 မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Tertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D0062895 DECEMBER 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 West Belvedere Ave. PAMLINE DALRY RICHTARDS 31. Date filed (Month, Day, Year) **DEC 2 8 2012** State parker Registrar DHMH 17 Rev 7/2009